Lighthouse Child & Family Services

Authorization for Release of Treatment Information

I authorize Lighthouse Child & Family Services to use or disclose the protected health information of the individual named below as indicated. Incomplete or invalid requests will be returned to the proper individual.

Client's Name:_____
First Middle Last

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth: _____ Phone:_____ Chart #:_____

Lighthouse Child and Family Services, including contracted staff is authorized to **SEND / RECEIVE** information with:

_____
Person/Group

_____
Address

_____
City, State, Zip

_____ _____
Phone Fax

Date(s) of Service to be Used/Disclosed: ____/____/____ to ____/____/____

Please check to indicate authorization of information to be exchanged:

_____Progress Notes	_____Medical/Medication Reports
_____Psychological Reports	_____Human/Social Service Info.
_____Treatment Plans	_____School Records
_____Diagnostic Assessments	_____Court Orders
_____Other_____	

The purpose for this request is (circle one or indicate other): Medical Care - Legal - Insurance - Research - Other:_____

I understand that sensitive information including information regarding HIV/AIDS, alcohol and drug abuse and/or mental health treatment may be released as part of this disclosure unless I initial here and indicate what sensitive information I do not want to disclose.
Initials:_____ Information Not to be Disclosed:_____

I understand that signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practice notices I have received. I understand that I can revoke this authorization in writing by sending notice to the facility releasing the above information. I understand that once information is disclosed it may no longer be protected by federal or state privacy rules and therefore may be redisclosed by the recipient of the information without protections.

Unless otherwise indicated here, this authorization shall expire in one year. Other Expiration Date:_____

I understand the terms of this form and authorize the disclosure/use as indication above.

_____ _____
Patient (or Patient Representative) Signature **Date**

_____ _____
Minor Signature (when appropriate) **Date**