Chart #: _____

Lighthouse Child & Family Services LLC

Check all that Apply

☐ ARMHS ☐ ARMHS Group
☐ CSP ☐ CSP Group

Client Information

Name of Client: _____ Date of Referral: _____

County: _____ Date of Birth: _____ Sex: _____M_____F_____Other

Address: _____ Phone #: _____

Diagnosis: _____ Alt Phone #: _____

Insurance Company: _____ Date Insurance Began: _____

Primary Client Policy ID#: _____ Group #: _____

Name of Policy Holder (if different from client): _____ Date of Birth: _____

Policy Holder Address: _____

Custodial Care Information (if applicable): _____

Referral Source Information

Name: _____ County: _____ Phone #_____

Address: _____ Fax #: _____

Reason for Referral:

_____

_____

_____

Current services and/or past services provided:

_____

_____

_____

An updated and completed Diagnostic Assessment is needed as well as a signed Release for your agency. Contact us if you need assistance in getting a Diagnostic Assessment. If sending a Diagnostic Assessment from another agency, please have the client sign the attached LCFS release to that agency, to allow communication between LCFS and the agency that completed the Diagnostic Assessment.

Please submit the referral form and attachments to:
Lighthouse Child & Family Services, LLC
160 3rd Avenue NW
Milaca, MN 56353
(320)983-2335
Or
Fax #: (651)342-8029

_____ _____

Signature of Individual Making the Referral Date

Lighthouse Child & Family Services LLC

160 – 3rd Avenue NW
Milaca MN 56353
320-983-2335
651-342-8029 Fax

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
_____Psychological Reports
_____Treatment Plans
_____Diagnostic Assessments
_____Other_____

_____Medical/Medication Reports
_____Human/Social Service Info.
_____School Records
_____Court Orders

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