150 10th St NW, Suite 2, Milaca, MN 56353
P: 320-983-2335 | F: 651-342-8029
www.lighthousecfs.com

AUTHORIZATION FOR THE RELEASE OF TREATMENT INFORMATION

I authorize Lighthouse Child & Family Services (LCFS) 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: _____ **Chart #**: _____
First Middle Last

Date of Birth: _____/_____/_____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

LCFS, including contracted staff, is authorized to (check one or both) ☐SEND / ☐ RECEIVE information with:

Person/Group: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date(s) of Service to be used/disclosed: _____/_____/_____ **TO** _____/_____/_____

Please check to indicate authorization of information to be exchanged:

☐ Progress Notes ☐ Diagnostic Assessments ☐ School Records
☐ Psychological Reports ☐ Medical/Medication Reports ☐ Court Orders
☐ Treatment Plans ☐ Human/Social Services Info ☐ Other: _____

The purpose for this request is (check one):

☐ Medical Care ☐ Legal ☐ Insurance ☐ Research ☐ Other: _____

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

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 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.

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

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

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