



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This authorization must be written, dated and signed by the consumer or by a person authorized by law.

Regarding: _____ **BIRTHDATE:** _____ **SSN:** _____

I will authorize Lighthouse Counseling to: **Release information to, and/or** **Receive information from:**

(Person/Organization)

(Telephone Number)

(Address)

Information will be used on my behalf for the following purpose(s): _____

By INITIALING the spaces below, I specifically authorize the release of the following medical/mental health records.

The information to be disclosed includes (**must be initialed by client and/or legal representative**):

YES	NO	
_____	_____	Social, medical, or psychological reports
_____	_____	Medication(s) used in treatment
_____	_____	Treatment goals and results
_____	_____	**Information about drug and/or alcohol abuse
_____	_____	**Mental health information
_____	_____	**HIV/AIDS related records
_____	_____	Other (specify): _____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS, mental health, drug/alcohol or genetic testing information.

I understand that this information may be shared via phone, fax, written, email or in person. The information being shared will be the minimum amount necessary to accomplish the purpose of this authorization. Refusal to sign this will not affect your ability to access health services.

I understand that I may revoke this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this written authorization. Any use or disclosure already made with my permission cannot be undone.

I have read this authorization and understand it. Unless revoked, this authorization will remain in effect for the duration of my treatment, **or** expires one year from the date of signature (whichever comes first).

***This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the patient.*

Date

Signature of client/guardian

Relationship to client if signed by guardian

Reason client is unable to sign

Witness signature

Date