**LILAC CITY COUNSELING, INC.**

361 Route 108, Unit 2, Somersworth, NH 03878

603-743-4004

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Client Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Authorization is hereby voluntarily granted to Lilac City Counseling, Inc. by the below signed client/guardian to exchange information with the following person or organization.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Person or Organization**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street City State Zip Telephone Fax

**METHOD FOR RELEASING:** (Check all that apply) 🞏 Oral 🞏 Written 🞏 Fax (fax cover sheet required) 🞏 Email (additional waiver required)

**INFORMATION TYPE**: The following checked items are being: 🞏 Released 🞏 Requested



🞏 Information regarding present psychological functioning

🞏 Psychological Testing 🞏 Summaries

🞏 School records & information 🞏 Court documents

🞏 Medical information 🞏 Court testimony

🞏 A complete copy of my medical record, including intake evaluations and psychotherapy notes.

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PURPOSE OF THIS INFORMATION:**

🞏 Facilitate assessment and treatment 🞏 Coordinate services with schools and other facilities

🞏 Facilitate authorization of treatment by managed care 🞏Coordinate treatment with other providers

🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I wish to limit the disclosure of information as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Release/Obtain alcohol & drug abuse information that is protected by Federal Confidentiality Rule (42CFR).& (NHRSA 141-F8)

🞏 YES I understand that I am not required to consent to the release of alcohol, drug and/or HIV information

🞏 YES 🞏 NO I give my consent to release/obtain drug and alcohol information

🞏 YES 🞏 NO I give my consent to release/obtain infectious disease information

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand that I can revoke this authorization in writing at any time**, except to the extent that Lilac City Counseling, Inc. has already taken action on this authorization. If not revoked beforehand, this authorization shall expire as follows:

(Check one) 🞏 One year from date of signature below

🞏 Upon reaching: (Specific date, event or condition) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once the requested information is disclosed pursuant to this authorization, Lilac City Counseling, Inc. will no longer have control over the information and there is a potential that it may be re-disclosed by the recipient and will no longer be protected by the privacy rules under the Health Insurance Portability and Accountability Act (HIPPA).

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Client Signature Date Witness Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (If applicable) Date