Lighthouse Counseling Intake

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AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

Client Name: _____ Birth Date: _____

Address: _____ Phone Number: _____

The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange With protected health information either orally or in writing.

NAME/INSTITUTION: _____ PHONE: _____

ADDRESS: _____ FAX: _____

PURPOSE. The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW

___ Assessment
___ Diagnosis
___ Psychological Evaluation
___ Treatment Plan or Summary
___ Progress in Treatment
___ Billing Information
___ Coordinate Treatment Services
___ Testing Information
___ Education Information
___ Presence/Participation in Treatment
___ Continuing Care Plan
___ Medication List
___ Verbal Consultation
___ Other_____

I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.
___Substance abuse (drug or alcohol) information
___Mental Health information
___AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months

X_____ _____
Signature Date

LIGHTHOUSE
COUNSELING
guiding families to a better life