

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned authorizes the release/exchange of information between:

Lighthouse Family Center, Ltd. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*2416 Whipple Ave. NW, Canton, Ohio 44708 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*213 Market Ave., N. Canton, Ohio 44702 Phone/Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*4526 Stow Rd., Stow, Ohio 44224

\*\* Phone (330) 305-2753 Fax (330) 639-1712

(Check one) \_\_\_From \_\_\_To \_\_\_Both (Check One) \_\_\_From \_\_\_To \_\_\_Both

The information is to be released for the specific purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ History & Physical \_\_\_ Medical Evaluation \_\_\_Summary of Treatment Results

\_\_\_ Admission Report \_\_\_ Chemical Dependency Eval \_\_\_ Progress Notes

\_\_\_ Diagnostic Assessment/ \_\_\_ Educational/Academic Testing \_\_\_ Discharge Summary

Psychological History \_\_\_ Work/Occupational Evaluation \_\_\_ Academic Records

\_\_\_ Psychological Evaluation \_\_\_ Service/Treatment Plan \_\_\_ IEP (Individualized Educ Plan)

\_\_\_ Psychiatric Evaluation \_\_\_ Record of Current/Past Medications

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

* This Authorization unless revoked expires one year from the date signed below.
* This information cannot be re-released without my specific written authorization.
* I may revoke this consent at any time by providing written revocation of consent, the agency will not release any information, except in the case where action has already been taken and where otherwise allowed by law.
* I understand that I may review the information to be released by contacting the releasing agency/individual named above.
* I understand that this provider will not condition treatment, payment, enrollment, or eligibility on this authorization for the release of information.
* I understand the consequences of refusal to sign an authorization for the release of information.

I expressly consent to the release of information designated above I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for mental illness (ORC5122.31), alcohol/drug use and/or abuse (42 CFR Part 2), and/or Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Parent/Guardian Date Signed Relationship to Client

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

Witness Date Signed

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Revocation of Consent:

I hereby withdraw my consent for any further release of information as of the date indicated below:

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

Signature of Client/Parent/Guardian Date Relationship to Client