LAKESIDE COUNSELING
C E N T E R

Consent for Release of Information

Patient's Name _____ Social Security Number: _____
Date of Birth: _____

I, (your name) _____
Authorize any representative of Lakeside Counseling Center
To _____ send and/or _____ receive (please initial your choice)
The following _____ to and/or _____ from (please initial your choice)

Name _____
Complete Address _____
Phone Number _____
Fax Number _____

(please initial your choice)

_____ Entire medical or psychological record, except psychotherapy notes
_____ Summary report or letter
_____ Treatment plan only
_____ Process Notes only
_____ Psychological reports
_____ Testing data
_____ Academic testing and/or report
_____ Medical records
_____ Insurance records
_____ Disability testing results
_____ Vocational testing results

The above information will be used for the following purposes: (please initial your choice)

_____ Planning appropriate treatment
_____ Continuing appropriate treatment
_____ Coordination of treatment
_____ Determining eligibility for benefits
_____ Case review
_____ Updating file
_____ Legal purposes
_____ Other - Describe _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Rules of Confidentiality of Alcohol and Drug Abuse Patient Records), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary and I may revoke this consent at any time by providing written notice. This notice will no longer be valid 6 month after final date of service. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the patient, please attach a copy of the legal documentation to this authorization.

Patient's signature _____

Date _____

Parent, guardian, or legal representative signature _____

Date _____