



## Release of Information

By signing this form, I authorize LifeCycle Family Counseling (LCFC) to disclose information about myself or my minor child to the person or entity specified below.

### **Recipient of Disclosed Information:**

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

**If the purpose is other than that as described above please specify:**

## Description of Information to be Disclosed

Click each box that you agree to:

### Information to be Disclosed

- Assessment
- Diagnoses
- Psycho-social Evaluation
- Psychological Evaluation
- Psychiatric Evaluation
- Treatment Plan or Summary
- Current Treatment Update
- Medication Management Information
- Presence/Participation in Treatment
- Nursing/Medical Information
- Educational Information
- Discharge/Transfer Summary
- Continuing Care Plan
- Progress in Treatment
- Demographic Information
- Psychotherapy Notes (CANNOT be combined with any other disclosure)

## Expiration

This authorization will automatically expire on the day of discharge from treatment. If you wish to specify a different expiration date, please provide it below.

### Expiration date



Month Day Year

## Acknowledgements

- I understand that I have a right to revoke this authorization at any time by notifying LCFC verbally or in writing. I further understand that any revocation will not apply to information that has already been disclosed.
- Unless I have specifically requested that the disclosure be made in a certain format, LCFC reserves the right to disclose information as permitted by this authorization in any manner deemed to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.
- I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.
- If I request it, I will be given a copy of this form for my records.

### Client Name \*

First Name      Last Name

### Date of Birth



Month   Day   Year

### Name of Parent or Legal Guardian If Different From Client

First Name      Last Name

### Date \*



Month   Day   Year

### Signature

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