LUTHERAN Community Services NORTHWEST

Health. Justice. Hope.

Authorization for Release of Information

Client Name: _____ DOB: _____ Date: _____

Client is hereby giving permission to Lutheran Community Services Northwest to: Initial _____ ☑ Mutually exchange

Entity/Individual Authorized for Release of Information: _____ Initial _____

Reason for releasing records: Initial next to any checked boxes

☐ To permit continuity of care ☐ To permit case management

☐ To permit reimbursement and processing of benefit claims ☐ Other (please specify): _____

I authorize the release of: Initial next to any checked boxes

☐ My entire chart ☐ A portion of my chart:

If a portion of the chart, specify the information authorized for release:

☐ Assessment and/or Treatment Plan	☐ Course and Progress in Treatment	☐ Urinalysis Testing (UA)
☐ Diagnosis or Status	☐ Coordination of Services/Case Management	☐ Lab Results
☐ Treatment Recommendations	☐ Billing Statement/Information	☐ Other: _____

I understand I have the right to receive a copy of this Authorization form and that a copy will be placed in my case record. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this Authorization form.

I understand that once LCSNW discloses my health information, LCSNW cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that, except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment at LCSNW, nor will LCSNW condition my treatment on whether I execute this authorization.

I understand that I have the right to revoke this Authorization at any time by providing a written statement of revocation to LCSNW. I am aware that my revocation will not be effective until received by LCSNW and will not apply to the uses and/or disclosures of my health information that LCSNW has made prior to receipt of my revocation statement.

I understand my records may contain sensitive information. I specifically authorize for the release of the following:

_____ Addictions Treatment Information Initial _____ Mental Health Information _____ HIV/AIDS Information

This release will expire

- on (date): _____; or
- when the following event occurs: at the termination of treatment.

Signature of Client or Authorized Representative _____

Signed by _____ Relationship if other than client _____

Witness Signature _____ Witness Name _____

NOTICE OF RECIPIENT INFORMATION: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation 42 CFR Part 2 prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.