



Authorization for Release of Information

Date:*

Client DOB:

Client First Name:*

Client Last Name:*

Participant is hereby giving permission to Lutheran Community Services Northwest to:

☐ Mutual Exchange

☐ Release from

☐ Release to

Entity/ Individual Authorized for Release of Information:* _____

Reason for releasing records:*

Relationship: _____

- ☐ To permit continuity or coordination of care Phone Number: _____
- ☐ To provide support services
- ☐ Other (please specify): _____

I authorize the release of: ☐ All of my information ☐ Only the following parts of my chart

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

- | | |
|---|--|
| ☐ Assessments and Treatment Plans | ☐ Diagnosis or Status |
| ☐ Billing Statement/Information | ☐ Treatment Recommendations |
| ☐ Coordination of Services/Case Management | ☐ Urinalysis Testing (UA) |
| ☐ Course and Progress in Treatment | ☐ Other: _____ |

I understand I have the right to receive a copy of this Authorization form and that a copy will be placed in my file. 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 information, LCSNW cannot guarantee that the recipient will not re-disclose my 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 information. I understand that, except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing information to a third party, I am not required to sign this authorization in order to receive support services at LCSNW, nor will LCSNW condition my assistance 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 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 ___ Mental Health Information ___ HIV/AIDS Information

This release will expire on (date): _____ or when the following event occurs:

If not otherwise specified, this authorization will expire one year from the date of signature.

Signature of Participant or Authorized Representative* _____

Signed By (write name): _____ Relationship if other than client* _____

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.