## **Authorization for Release of Information to LAMOUR Clinic**

Patient First Name:	Patient Last Name:			Patient DOB:				
*Staff Completing this form must be completed with full contact information for and one consent for each, School, State Agency, Community Agency, Clinic, Hospital, HealthCare Facility Specialty Services Provider, Emergency Contact given, Courts Administrators, State agency DYS, DCF, DMH, MRC Probation or Court Involvement & Mandated Information before patient signatures and inform patient of 42 C.F.R Part 2 rights **								
A. To another Agency or Individual hereby grant permission for the agency or needed for me or my child evaluation, treatn to receive and release information from e	individual n nent and/or	need information	n to participate in p	rogram service	es by LAMOUR Clinic. <i>I authorize</i>			
B. To LAMOUR Clinic hereby grant permission as being a Parent egarding the patient evaluation and/or treat collaboration in treatment below.	/Guardian							
c. To LAMOUR Clinic hereby grant permission for the LAMOUR ( reatment to MRC, DDS, DCF, DMH, DYS, a	Clinic to dis							
There must be one co	nsent co	mpleted for ea	ch of the boxes	checked ab	ove and below			
□ School Counselors, Administrators,  Teacher and staff verbal communication □ Attendance records □ Individual Education Plans and immunizations □ Education Testing  understand that my substance use diso Substance Use Disorder Patient Records "HIPAA"), 45 C.F.R. pts 160 & 164, and compared to the expectation at any time except to the except will expire automatically as folloogen.	screening, Diagno. Treatm Psycho Substal Drug Testi	ds are protected Part 2, and the disclosed withou ny signatures d	d under the Federa Health Insurance ut my written consate on this form.	BSAS Consand HIPPA Legal Guar Legal Guar Courts Adn Results Coordinate Dental, or any treatment goals Other (Plea  al regulations Portability ansent unless of understand	or Setup of Referrals for Medical, other appointment related to see be Specific  governing Confidentiality and d Accountability Act of 1996 therwise provided for by the that I may revoke this			
Print Individual Name:								
School/Agency/Clinic/Hospital/ HealthCa	are Facility	<i>r</i> :						
Address:			wn:		Area code:			
Phone:			Fax:					
**Mus	st be signe	d by adult in cu	stody if patient is	under 18**				
Printed Patients Name:			-					
Patients Signature:								
Date Signed:								
Printed Parent/Guardian/Adult in Custoo	ly:							
Parent/Guardian Signature:	-		Relationship to p	patient:				
Date Signed:			- •					

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*Staff Completing this form must be comple Community Agency, Clinic, Hospital, Health State agency DYS, DCF, DMH, MRC Prob Deatient of 42 C.F.R Part 2 rights **	Care Facilit	y Specialty Servi	ices Provider, Eme	rgency Contac	t given, Courts Administrators,
A. To another Agency or Individual hereby grant permission for the agency or needed for me or my child evaluation, treatn to receive and release information from e	individual n nent and/or	need information	n to participate in p	rogram service	es by LAMOUR Clinic. <i>I authorize</i>
B. To LAMOUR Clinic hereby grant permission as being a Parent egarding the patient evaluation and/or treat collaboration in treatment below.	/Guardian				
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There must be one co	nsent co	mpleted for ea	ch of the boxes	checked ab	ove and below
□ School Counselors, Administrators,  Teacher and staff verbal communication □ Attendance records □ Individual Education Plans and immunizations □ Education Testing  understand that my substance use diso Substance Use Disorder Patient Records "HIPAA"), 45 C.F.R. pts 160 & 164, and compared to the expectation at any time except to the except will expire automatically as folloogen.	screening, Diagno. Treatm Psycho Substal Drug Testi	ds are protected Part 2, and the disclosed withou ny signatures d	ion essment ns ation History including d under the Federa Health Insurance ut my written cons ate on this form.	BSAS Consand HIPPA Legal Guar Legal Guar Courts Adn Results Coordinate Dental, or any treatment goals Other (Plea	or Setup of Referrals for Medical, other appointment related to see be Specific  governing Confidentiality and d Accountability Act of 1996 herwise provided for by the that I may revoke this
Print Individual Name:					
School/Agency/Clinic/Hospital/ HealthCa	are Facility	<i>r</i> :			
Address:			wn:		Area code:
Phone:			Fax:		
**Mus	st be signe	d by adult in cu	stody if patient is	under 18**	
Printed Patients Name:					
Patients Signature:					
Date Signed:					
Printed Parent/Guardian/Adult in Custoo	ly:				
Parent/Guardian Signature:	-		Relationship to p	patient:	
Date Signed:			- •		

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**Staff Completing this form must be completed with full contact information for and one consent for each, School, State Agency, Community Agency, Clinic, Hospital, HealthCare Facility Specialty Services Provider, Emergency Contact given, Courts Administrators, State agency DYS, DCF, DMH, MRC Probation or Court Involvement & Mandated Information before patient signatures and inform patient of 42 C.F.R Part 2 rights **  A. To another Agency or Individual Please check here   I hereby grant permission for the agency or individual named below to discuss or send the information checked below regarding information needed for me or my child evaluation, treatment and/or need information to participate in program services by LAMOUR Clinic. I authorize to receive and release information from either verbally or in writing, as indicated in this authorization.									
B. To LAMOUR Clinic Please check here  I hereby grant permission as being a Parent/Guardian of the patient for LAMOUR Clinic to discuss or send the information checked below regarding the patient evaluation and/or treatment to Court Officer, MCR, DDS, DCF, DMH, DYS, and or the agency named below as collaboration in treatment below.									
C. To LAMOUR Clinic Please check here  I hereby grant permission for the LAMOUR Clinic to discuss or send the information checked below regarding my evaluation and/or treatment to MRC, DDS, DCF, DMH, DYS, and or the agency named below as collaboration in treatment below.									
There must be one co	nsent completed for ea	ach of the boxes	checked ab	ove and below					
School Counselors, Administrators,	☐ History & All medication le	ead poisoning	☐ Community	Services Agency					
Teacher and staff verbal communication	screening, physical examinat	ion	☐ BSAS Cons	sent to Individual Recipient 42 Part 2					
☐ Attendance records	☐ Diagnostic Treatment Ass	essment	and HIPPA						
☐ Individual Education Plans and	☐ Treatment/ Discharge Pla	ns	☐ Legal Guar	dians/ Attorneys & Legal Advocates					
immunizations	☐ Psychology Testing Evalu	ation	☐ Emergency	Contact					
☐ Education Testing	☐ Substance Abuse Record		☐ Courts Adm	ninistrators and Probation Officer					
	Drug Testing Results		Results						
			⊠ Coordinate	or Setup of Referrals for Medical,					
				other appointment related to					
			treatment goals						
			☐ Other (Plea						
I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. My consent is valid for one year from my signatures date on this form. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:									
Print Individual Name:									
School/Agency/Clinic/Hospital/ HealthCa	are Facility:								
Address:	То	wn:		Area code:					
Phone: Fax:									
**Must be signed by adult in custody if patient is under 18**									
Printed Patients Name:									
Patients Signature:									
Date Signed:									
Drinted Berent/Cuardian/Adult in Cuatedu									
Printed Parent/Guardian/Adult in Custody:									
Parent/Guardian Signature: Relationship to patient:									
Date Signed:									