

Authorization for Release of Information to LAMOUR Clinic

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|----------------------------|---------------------------|---------------------|
| 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 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 consent completed for each of the boxes checked above and below | | |
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| <input type="checkbox"/> School Counselors, Administrators, Teacher and staff verbal communication <input type="checkbox"/> Attendance records <input type="checkbox"/> Individual Education Plans and immunizations <input type="checkbox"/> Education Testing | <input type="checkbox"/> History & All medication lead poisoning screening, physical examination <input type="checkbox"/> Diagnostic Treatment Assessment <input type="checkbox"/> Treatment/ Discharge Plans <input type="checkbox"/> Psychology Testing Evaluation <input type="checkbox"/> Substance Abuse Record History including Drug Testing Results | <input type="checkbox"/> Community Services Agency <input type="checkbox"/> BSAS Consent to Individual Recipient 42 Part 2 and HIPPA <input type="checkbox"/> Legal Guardians/ Attorneys & Legal Advocates <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Courts Administrators and Probation Officer Results <input checked="" type="checkbox"/> Coordinate or Setup of Referrals for Medical, Dental, or any other appointment related to treatment goals <input type="checkbox"/> Other (Please be Specific) |

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/ HealthCare Facility: | | |
| Address: | Town: | Area code: |
| Phone: | Fax: | |

****Must be signed by adult in custody if patient is under 18****

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| Printed Patients Name: |
| Patients Signature: |
| Date Signed: |

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| Printed Parent/Guardian/Adult in Custody: | |
| Parent/Guardian Signature: | Relationship to patient: |
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