Authorization for Release of Information to LCHI 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 **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 LCHI Clinic. ***I authorize to receive and release information from either verbally or in writing, as indicated in this authorization.***

B. To LCHI Clinic **Please check here** ☐
I hereby grant permission as being a Parent**/Guardian of the patient for** LCHI 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 LCHI Clinic **Please check here** ☐
I hereby grant permission for the LCHI 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		
☐ School Counselors, Administrators, Teacher and staff verbal communication ☐ Attendance records ☐ Individual Education Plans and immunizations ☐ Education Testing	☐ History & All medication lead poisoning screening, physical examination ☐ Diagnostic Treatment Assessment ☐ Treatment/ Discharge Plans ☐ Psychology Testing Evaluation ☐ Substance Abuse Record History including Drug Testing Results	☐ Community Services Agency ☐ BSAS Consent to Individual Recipient 42 Part 2 and HIPPA ☐ Legal Guardians/ Attorneys & Legal Advocates ☐ Emergency Contact ☐ Courts Administrators and Probation Officer Results ☒ Coordinate or Setup of Referrals for Medical, Dental, or any other appointment related to treatment goals ☐ 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****

Printed Patients Name:
Patients Signature: **Date Signed:**

Printed Parent/Guardian/Adult in Custody:	
Parent/Guardian Signature: **Date Signed:**	**Relationship to patient:**

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