Client Name:

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client's Name: _____ DOB:_____

***** COMPLETE ONE (1) FORM per entity with whom you give permission for Lukas Counseling LLC to share information*****

I authorize Lukas Counseling LLC to discuss details of my case and/or to disclose certain protected health information (PHI) to the individual or agency listed below. I understand the information shared is for coordination of care and will be on a need-to-know basis, and that my confidentiality of specific session details is still protected except in situations that require legal notification of other agencies, such as in cases of abuse.

RELEASE AND RECEIVE INFORMATION WITH:

*(name of agency/physician/person)*_____

Fax _____ Phone _____

Address: _____ Suite # _____

City _____ State _____ Zip Code _____

Requested Delivery Method:

[___] Fax [____]Mail [____]Phone [____]E-mail [____]Face to Face [____] Other

Purpose:

[___] At the request of the client/ guardian [____] Treatment / Service Coordination

[___] Disability Application [____] Other:_____

I authorize to release:

_____Psychiatric or Psychosocial Evaluations

_____Mental Health Records

_____Substance Abuse Records

_____Medications & Dosages

_____Summary of Progress Notes

_____Educational Records

_____Physical Health Records/Summary

_____Other:

Other Instructions: (note: Florida law requires a court order to prevent information release to biological parents or other identified legal guardians):

I understand that only the above-specified information can be disclosed by the above-specified organization. This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the 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 [52 FR 21809, 1987; 52 FR 41997, Nov. 2, 1987] - This consent or authorization for release of information shall be effective the date of signature and shall expire one year from the date of signature below or at the time services are concluded if before one year. I also understand that I may revoke this consent or authorization at any time, providing I notify the program in writing to this effect. Revocation has no effect on action previously taken. A copy or electronic copy of this document shall be as valid as the original.

Unless I provide other instructions IN WRITING,
This authorization expires 2 (two) years from the date signed, or on ___/____/_____

Please submit this request to us in person (by appt only) or: **Fax – 561-430-2039 or E-mail – referrals@lukascounseling.org**

Or Mail: ***LUKAS COUNSELING LLC, P.O.BOX 784719 WINTER GARDEN FL 34778***

Client (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Guardian (Print)	**(Sign)**	**Date**
Witness (Print)	(Sign)	Date