Lighthouse Counseling Services, LLC

Release of Information Consent Form

I, _____ , authorize Lighthouse Counseling Services, LLC. to:

_____ Send _____ Receive the following information
_____ To _____ From the following agencies or people

Name			
Address			
City		State	Zip
Phone		Fax	

Name			
Address			
City		State	Zip
Phone		Fax	

	Academic testing results		Psychological testing results
	Behavior Programs		Service plans
	Case notes		Summary reports
	Intelligence testing results		Vocational testing results
	Medical reports		Entire record
	Personality profiles		Other (specify below)
	Progress reports		
	Psychological reports		

The above information will be used for the following purposes:

	Planning appropriate treatment or program
	Continuing appropriate treatment or program
	Determining eligibility for benefits or program
	Case review
	Updating files
	Other (specify below)

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's name (please print)		DOB	
Client's signature		Date	
Spouse/Parent signature		Date	
Witness (if client is unable to sign)		Date	
Person informing client of rights		Date	

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