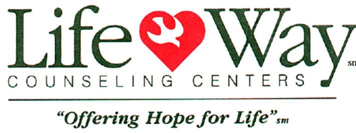

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

____
Patient Name

_______________________________________ _______________________________________
Date of Birth Phone

I, ____,
(Print Name)
do consent to unlimited communication regarding my/my child's assessment interview, psychiatric and psychological records, treatment progress and summaries.

Records: To / From (Pease Cirlce)	**Records: To/ From** (Please Circle)
Lifeway Counseling Centers 11161 Kenwood Rd Cincinnati, Ohio 45242 Phone (513) 769-4600 Fax (513) 769-0304 Attn: Medical Records	Name____ Address____ ____ Phone_____________________Fax_____________________

This information is considered instrumental to the ongoing evaluation and treatment of this client.
Information requested include(s):

_____Psychiatric Information
_____Psychological Therapy/Testing
_____Medical Information/Lab Results
_____Verification of Assessment and Progress of Treatment
_____Treatment and Discharge Summary
_____Educational Records
_____Legal Information
_____Social Welfare Data
_____Rehabilitation Records
_____Other:____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) and drug and alcohol abuse, drug-related conditions, and/or alcoholism. I authorize the release or disclosure of this information.

Confidentiality will be maintained within the supervisory-counselor relationship, except when there appears to be imminent danger to you or others. I understand this authorization may be revoked in writing or in person to Lifeway Counseling Centers at any time except to the extent action has been taken prior to revocation. This consent will expire in sixty (60) days after the date below, or sooner at my election in which case this authorization will expire on ______________.

You agree to hold LifeWay Counseling Centers, Inc. harmless from any claim or liability (including, but not limited to, any claim brought under a confidentiality or privacy law) in connection with the release at your request of the information and records described above. Thus, I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

Further, Lifeway will not condition treatment, payment, health plan enrollment and/or plan eligibility on the refusal to sign this authorization; however information will not be released without signature.

I acknowledge that I have read and fully understand this authorization as it applies to me.
A photo static copy of this form is to be considered the same as the original.

Signatures:_______________________________________ _______________________________ ______________
Client or Guardian Relationship to Client Date

_______________________________________ ______________
Witness Date