LIGHTHOUSE
MENTAL WELLNESS

REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: _____
Date of Birth: _____

I hereby authorize: (Name and address of **outside** provider)

_____
_____
_____

To □ send / □ receive the following information from the record of the above named client:

□ Psychiatric evaluation
□ Progress Notes; Psychotherapy Notes
□ Medical Exam/Lab Results
□ Psychological Testing Results
□ Case History
□ Hospital Admission and Discharge Summaries
□ Other _____
□ All health information, excluding _____

This information is needed for the purpose of coordination of care.

I understand that my record may contain information about infectious diseases including HIV/AIDS status, alcohol or drug abuse, STDs, information relative to the diagnosis and treatment of my mental or emotional conditions. I consent to this information being disclosed. I understand that the provider abides by Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191which protects the confidentiality of the record and that information in my record cannot be disclosed without consent unless otherwise provided for in the regulation.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon termination of care or from date: _____

I herewith release and hold harmless Lighthouse Mental Wellness, PLLC and any contractors, agents, employees, directors or volunteers from any liability for the release of information provided in accordance with this directive.

If information is requested, please send to:

Lighthouse Mental Wellness, PLLC
28 Riverside Drive, Suite 260
Pembroke, Ma 02359

Phone: 781-427-7070
Fax: 781-427-7071

Signed under the pains and penalties of perjury:

Signature: _____ (Client/Guardian) **Date:** _____

* **REVOCATION** OF REQUEST FOR INFORMATION- *To be signed when revoking this release.**

Signature: _____ (Client/Guardian) Date: _____