LODESTONE

CENTER FOR BEHAVIORAL HEALTH

Release of Information

Patient Information:

FULL NAME: _____ DATE OF BIRTH: _____

I HEARBY AUTHORIZE THE LODESTONE CENTER FOR BEHAVIORAL HEALTH TO RELEASE WRITTEN, VERBAL OR ELECTRONICALLY TRANSMITTED INFORMATION AS DOCUMENTED BELOW WITH:

ORGANIZATION/INDIVIDUAL: _____ FAX: _____

ADDRESS: _____ PHONE: _____

_____

Nature Of Information To Be Disclosed:

☐ PSYCHIATRIC RECORDS ☐ INTAKE AND DISCHARGE SUMMARIES ☐ MEDICAL RECORDS

☐ PSYCHOLOGICAL EVALUATIONS ☐ PROGRESS NOTES/TREATMENT PLANS ☐ EDUCATION RECORDS

☐ TELEPHONE/EMAIL COMMUNICATION ☐ OTHER _____

FOR THE PURPOSE OF: ☐ COORDINATION OF CARE ☐ TREATMENT PLANNING ☐ OTHER _____

THIS CONSENT EXPIRES ON: _____ /_____ /_____ IF A DATE IS NOT PROVIDED, INFORMATION MAY BE RELEASED ONLY ON THE DAY THE CONSENT FORM IS RECEIVED BY THE THERAPIST.

THE CONSEQUENCES OF REFUSAL TO CONSENT, IF ANY ARE: ☐ RECORDS WILL NOT BE RELEASED

☐ OTHER _____

I HAVE THE RIGHT TO INSPECT AND COPY THE INFORMATION TO BE DISCLOSED. THIS REQUEST IS ENTIRELY VOLUNTARY ON MY PART. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME.

_____	_____	_____	_____
PRINTED NAME OF PATIENT	DATE	SIGNATURE OF PATIENT	DATE
_____	_____	_____	_____
SIGNATURE OF PARENT OR GUARDIAN (MINOR UNDER 12)	DATE	WITNESS SIGNATURE	DATE