

LPA Counseling
2005 Valparaiso Street, Suite 209
Valparaiso IN 46383
PH: (219)252-5464 FAX: (219)728-1860

Request/Consent to Release Confidential Information

I hereby authorize mutual release of information between LPA CO. and:

Person/Facility:			
Address:			
Phone/Fax:			
For health records about (Name):			
Date of Birth (MM/DD/YYYY):		Address:	

For the following purpose(s):

<input type="checkbox"/>	Mental health evaluation, treatment, or continuity of care	<input type="checkbox"/>	Consultation or Coordination of Care
<input type="checkbox"/>	Rehabilitation program, development, or services	<input type="checkbox"/>	Treatment Planning
<input type="checkbox"/>	Research	<input type="checkbox"/>	Other

Specific or approximate date(s) of service _____

The information to be disclosed is marked by an X in the boxes below.

<input type="checkbox"/>	Medical History, Evaluations, or test results.	<input type="checkbox"/>	Mental Health evaluations
<input type="checkbox"/>	Developmental and/or Social History	<input type="checkbox"/>	Educational Records
<input type="checkbox"/>	Intake and discharge summaries	<input type="checkbox"/>	Progress Notes, and/or Treatment Notes/Closing Summary
<input type="checkbox"/>	Other:	<input type="checkbox"/>	
<input type="checkbox"/>	Please forward the records to the address in the letterhead at the top of this form.		
<input type="checkbox"/>	Please forward the records to the address written above.		
<input type="checkbox"/>	Please consult by telephone.		

I understand and or have had explained to me this request and consent for release of confidential records and information, including the nature of the records, their contents and the implications or consequences of their release. I understand I may withdraw my consent prior to the time information is actually shared. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

<input type="checkbox"/>	Authorizing a one-time release	<input type="checkbox"/>	Authorizing ongoing consultation
Client Signature & Date		Printed Name	
Parent Signature & Date		Printed Name/Relationship	
Witness Signature, Date		Printed Name	