Lakeland Mental Health Center, Inc. Authorization for Release of Health Information

Client Information	LMHC#___________________________ Client Name: ____ Date of Birth: _____________________ Previous Name(s): ____ Address: ____ Phone:_________________________ City: ___________________________________ State: ___________________ Zip Code: ________________ E-mail: (optional): ____
I Authorize	**Lakeland Mental Health Center (LMHC)** To do the following: ☐ Release To ☐Receive From ☐Both Release & Receive ☐ Fergus Falls, MN 56537 - 980 South Tower Rd – Tel: 218-736-6987 ☐ Moorhead, MN 56560 – 1010 32nd Ave South – Tel: 218-233-7524 ☐ Alexandria, MN 56308 – 702 34th Ave East – Tel: 320-762-2400 ☐ Detroit Lakes, MN 56501 – 928 8th Street SE – Tel: 218-847-1676 ☐ Glenwood, MN 56334 – 14 6th Ave NW – Tel: 320-634-3446
With	Agency/Name: ____ Relationship:_________________ Address: ____ Fax: ________________________ City: ___________________________________ State: ___________________ Zip Code: ___________________ Phone number: __________________ E-mail (optional): ____
What do you want released?	☐ Record Dates between: _________________________________ to _________________________________ ☐ Diagnosis ☐ Diagnostic Assessment ☐ Psychiatric Evaluation ☐ Psychological Assessment & Testing ☐ History of Trauma/Injury ☐ Progress Notes ☐ Medications ☐ Lab Reports ☐Substance Use Info ☐ Admit/Discharge Dates & Reports ☐ Emergency Notification Info ☐ Family Involvement Info ☐ School Reports/IEP ☐ Recommendations ☐ Functional Assessment ☐ Treatment Plan ☐ Verbal ☐ Other ____
Purpose of Release	☐ Diagnosis & Treatment ☐ Coordination & Follow-up ☐ Update Record ☐ Referral ☐ Education Purposes ☐ CSP Participation ☐ Legal ☐ Personal/Client Request ☐ Insurance Purposes ☐ Emergency notification ☐On-Site Chart Review ☐ Other ____________________________________
Substance Use Disorder (SUD) Special Consent	Per Federal Rule 42 CFR, part 2 this section must be completed to release SUD records ☐ SUD Comprehensive Assessment & Assessment Summary ☐ SUD Discharge Summary ☐ SUD Weekly Summary Notes ☐ Other: ____
Preferred Method	☐ Mail ☐ Pick-up ☐ Secure Fax _________________ ☐ Secure E-mail ______________________________
Authorization	This consent will end one year from the date of the signature below unless I indicate an earlier expiration date or event here: ____ **Client Signature**: ____ Date: ____/____/____ OR legally authorized representative's signature: _______________________________ Date: ____/____/____ Representative's relation to client (parent, guardian, etc.) ____

LMHC will not condition my treatment, payment, enrollment, or eligibility for benefits by signing this authorization. I authorize LMHC to disclose the above stated records to the Name/Organization listed above. I understand this may include information regarding mental health, alcohol/drug use, and HIV records unless initialed below. I do not need to sign this authorization to receive services unless the services are court ordered or are being created solely for a third party. This consent will expire upon fulfillment of its stated purpose or one year from date of signature. I understand that I may revoke this consent by written notice at any time except (1) when legal action prevents revocation (probation, parole, court confinement), or (2) when requested by my insurance company, as the law provides my insurer the right to consent a claim under my policy. Any release made in good faith, prior to receipt of revocation, shall be deemed valid. This release of information must be filled out completely, signed and dated. A photocopy and/or facsimile of this authorization may be treated in the same manner as the original; however, LMHC reserves the right to require an original consent. I understand the protected health information used or disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected. I will receive a copy of this signed form upon request.

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INITIALED BELOW:

__________ **Do NOT** release alcohol or drug treatment records protected under federal law.