

**LUTHERAN SOCIAL SERVICES
AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION**

Client Name _____

Social Security Number _____ Date of Birth _____

INFORMATION EXCHANGED / RELEASED FROM

Lutheran Social Services

INFORMATION EXCHANGED / RELEASED TO

Agency _____
Address _____
Phone _____
Contact _____

Specific type of information to be disclosed / obtained:

- Diagnosis
- Diagnostic Assessment Information
- Psychiatric Evaluation
- Progress in Treatment / Attendance
- Discharge Summary
- Individual Service Plan
- Medication Records
- Other: Information regarding program attendance and recommendations

Purpose and need for such disclosure / information:

- Continuity of care
- Treatment Compliance
- Employment
- Legal
- Family Involvement
- Physician Involvement
- School Involvement

Amount of Information to be Disclosed:

- Information covering the previous three months
- Information covering most recent admission
- Other amount of information (specify): Information regarding program(s) attended

Method of Release: Written Verbal Fax E-mail Audio Video

I hereby authorize the release and/or exchange of the above identifying information from my records. I hereby release Lutheran Social Services, from all legal responsibility or liability that may arise from this authorization. This consent is subject to revocation by me at any time, except to the extent that the program which is to make this disclosure has already taken action in reliance upon it. Lutheran Social Services may not condition treatment of me on whether or not I revoke this release of information. This release will remain in effect:

365 days from date of signature _____
(time or event when consent will expire)

I understand that this release will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.

Signature of Authorizing Person

Date

Witness

Date

If Authorizing Person is a minor, signature of parent / guardian

Date

NOTICE: Although HIPAA regulations state that information disclosed may be subject to redisclosure by persons receiving it and is not protected by the federal privacy regulations, this information **is protected** by **Federal** confidentiality rules as stated: "This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

NOTICE OF CANCELLATION: Date _____ Time _____

Mode of Cancellation: (telephone, letter, etc.) _____

Staff Signature _____