LIGHTHOUSE COUNSELING of Fredericksburg, PLC
420 Hudgins Road Suite 201, Fredericksburg, VA 22408

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, **(Name)_____(DOB)_____** hereby authorize

Lighthouse Counseling to exchange information obtained in the course of my treatment and evaluation with

Name and Address: _____

Phone: _____ Fax: _____

for the purposes of ___ Therapy, ___ Coordination of Care, ___ other_____ and that such

exchange shall be limited to the following specific types of information: __ Assessment, ___ Progress,

___ Test results, ___Discharge, other _____. I wish to further limit the information

released to include only: _____

By Signing below I have taken the opportunity to ask any questions and understand that:

- I have a right to receive a copy of this authorization and to refuse to sign it.
- I understand that I have a right to cancel or modify this authorization at any time, though I understand Lighthouse Counseling staff may have already released information prior to its removal.
- Lighthouse Counseling will not refuse treatment because you do not sign this authorization, unless permitted by law and stated in this authorization.
- Lighthouse Counseling staff may require information and coordination with others (including therapists, doctors, etc.) in order to ethically provide treatment.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, unless prohibited by other laws and regulations including 42 CFR, Part 2 mentioned below.
- I understand and/or have had explained to me this authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release.
- This authorization to release records includes information placed in my record after this date but before the expiration date.
- If applicable, HIV related information contained in these records will be released under this consent unless indicated here ____ Do Not Release
- This consent automatically expires when your case is closed or by (insert date):_____
- If applicable: If authorization is signed by an authorized representative, a description of the authorized representative's authority to act. _____

NOTE WHERE INFORMATION ACCOMPANIES THIS RELEASE FORM: This information has been disclosed to the recipient from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit recipient 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 release of information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug using clients.

Signature of Client/Guardian: _____ **Date:** _____