☐ Fergus Falls, MN 56537	980 South Tower Road	Tel: 218-736-6987	Fax: 218-736-6980
☐ Detroit Lakes, MN 56501	928 8th Street S.E.	Tel: 218-847-1676	Fax: 218-847-1678
☐ Moorhead, MN 56560	1010 32nd Avenue South	Tel: 218-233-7524	Fax: 218-233-8627
☐ Glenwood, MN 56334	100 17th Ave NW Suite # 2	Tel: 320-634-3446	Fax: 320-634-0384
☐ Alexandria, MN 56308	1500 Irving Street	Tel: 320-762-2400	Fax: 320-762-8047

Lakeland Mental Health Center, Inc. Authorization For Release Of Clinical Information

Name of Client: ______________________ **Birth Date:** ______________ **LMHC #:** __________

I, the undersigned, hereby authorize Lakeland Mental Health Center, Inc. to:

☐ **Disclose To** ☐ **Obtain From** ☐ **Disclose To and Obtain From**

Name of Person or Organization: ____

Address: ____

City/State: ____________________ **Zip:** __________ **Phone #:** ____________ **Fax #:** ____________

Specific information to be disclosed:

☐ Diagnosis
☐ Diagnostic Assessment
☐ Psychiatric Evaluation
☐ Psychological Assessment and Testing
☐ Verbal
☐ Admit/Discharge Dates & Reports
☐ Progress Reports
☐ Medications
☐ Laboratory Reports
☐ Chemical Dependency Information
☐ History of Trauma/Injury
☐ Emergency Notification Info.
☐ Family Involvement Information
☐ School Reports/IEP
☐ Recommendations
☐ Results / IEP Type of Assessment: ______________________ ☐ Other (Specify): ________________

Dates of documentation being requested: ☐ All available ☐ Info from: ____________ to ____________

The information is necessary for:

☐ Diagnosis & Treatment
☐ Acknowledge Referral
☐ Legal
☐ Coordination & Follow-Up
☐ Insurance Purposes
☐ Personal Record
☐ Family Involvement
☐ Education Purposes
☐ Emergency Notification
☐ Update Record
☐ CSP Participation
☐ On-Site Chart Review
☐ Other (Specify): ______________________

Revocation & Expiration of Consent:

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 to release information 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 contest a claim under my policy. Any release made in good faith, prior to receipt of revocation, shall be deemed valid. 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 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 (i.e., consultation).
- This release of information will be accepted only if all items have been completed.
- A fee may be assessed for the requested records.
- Requested information may be released directly to the person, or by mail, phone or fax.

Chemical Dependency Authorization:

Chemical Dependency records are further protected by a more stringent Federal Law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the patient nor can the information be re-disclosed unless specifically authorized by the patient or as otherwise permitted by 42 CFR Part 2.

I authorize all records pertaining to psychiatric/mental health, chemical dependency and or HIV/AIDS related content to be released unless otherwise indicated here.

DO NOT release records regarding: ☐Psychiatric Mental Health ☐Chemical Dependency ☐HIV/AIDS related information

Client's Signature: ________________________________ **Date:** __________

Parent/Guardian (Print): ____________________ **Signature:** ____________________ **Date:** ________

Witness Signature: ________________________________ **Date:** __________

If the client is unable to sign, the person signing the authorization will be required to show proof of guardianship or other authority and the relationship to client, allowing him/her to authorize the release of information.