Lightship Family Counseling, LLC
24 Battle Street, Suite 2A Room 1, Somers, CT 06071
Phone: 860-331-9548 Fax: 860-969-2939
Secure Email: LFC@counselingsecure.com
Email: lightshipfamilycounseling@gmail.com

AUTHORIZATION TO OBTAIN/DISCLOSE INFORMATION TO/FROM

I hereby authorize Lightship Family Counseling, LLC to: (check one or both)

_____ Disclose (share/send/allow access to) information about me and my medical/service/educational records
_____ Obtain (receive/request/obtain access to) information about me and my medical/service/educational records

To/From: Name and address of third party organization or individual:

Name: _____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number: _____ Other Phone:_____

Fax Number: _____ Email:_____

The information that is obtained/disclosed/accessed might include my service, treatment and/or educational information related to my diagnosis or treatment of my psychiatric disabilities, substance misuse disabilities, medical/dental conditions, or my genetic or HIV-related information. The information may be obtained/disclosed in verbal, written, and/or electronic format.

The purpose(s) of this disclosure is/are as follows (Please check ones you consent to share)

_____ Treatment planning, communication, coordination
_____ Discharge planning and referral
_____ Court related or legal
_____ Disability determination or re-determination
_____ Educational/IEP Planning
_____ At request of the individual (no statement of purpose necessary)

_____ Other (specify)_____

Optional Section: Please describe any information which you would like Lightship Family Counseling, LLC NOT to disclose about you: _____

I understand that:

Under the applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may not be protected by federal privacy regulations.

- I may revoke this authorization in writing at any time but contacting Lightship Family Counseling, LLC at 860-331-9548, except that it will not have any effect on actions taken by Lightship Family Counseling, LLC or the recipient organization before it received my written revocation/restriction request.
- I may receive a copy to inspect the information to be used or disclosed by this authorization
- I may refuse to sign this form and that my refusal to sign this authorization will not jeopardize the right to obtain present or future treatment.
- Confidential HIV-related information that may be disclosed includes whether the client has been counseled regarding HIV, has been the subject of an HIV test, or has HIV, HIV related illness or AIDS, and also could include information pertaining the the client's spouse, sexual partner, or person with whom the client shared needles or syringes.
- If the client is a minor (age 17 and under), any disclosure of drug and alcohol misuse records, outpatient mental health records for treatment provided with the minor's consent only under 19a-14c, and/or HIV-AIDS-related information requires the consenting signature of the minor client below. Without such signature, Lightship Family Counseling, LLC will not disclose such records or information to the third party named above.

This authorization will expire on (one year from date of signed or when revoked in writing by client)

Authorization to Disclose/Obtain/Access Information

By signing below, I acknowledge that I have read and understand this authorization. My signature below serves as attestation to the fact that I am the client, or I am the legal guardian of the child whose health information I am authorizing disclosure of.

_____ _____

Client Date

_____ _____

Parent/Guardian Date