LIGHTHOUSE

counseling services, inc.

AUTHORIZATION TO RELEASE INFORMATION

Client Information

Client Name: _____ DOB: ___/___/_____

Phone: _____ Address: _____

SSN: _____ Medicaid # (if applicable): _____

I request and authorize the release of health information for the above named client between:

Please select office location:

□ Greenville - 134 N. Main St. Greenville, KY 42345 Phone 270-377-7120 Fax 270-641-0322
□ Henderson - 203 N. Elm St. Henderson, KY 42420 Phone 270-826-8761 Fax 270-826-8737
□ Madisonville – 145 E. Center St. Ste 1D Madisonville, KY 42431 Phone 270-821-8884 Fax 270-821-8885
□ Morganfield – 130 N. Morgan St. Ste 201 Morganfield, KY 42347 Phone 270-389-4405 Fax 270-389-4813
□ Owensboro – 920 Frederica St. Ste 407 Owensboro, KY 42301 Phone 270-689-0073 Fax 270-689-0083

AND

Individual/Organization: _____

Address: _____ Phone: _____

The request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates:

_____

_____ or ___/___/_____ to ___/___/_____

□ All healthcare information

□ Other:

_____

□ Yes □ No	I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
□ Yes □ No	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Client Signature: _____ Date: ____/____/_____

Parent/Guardian: _____ Date: ____/____/_____