**Authorization For Use And Disclosure Of Protected Health Information**

**INSTRUCTIONS:**  Provide information as it existed when the service was provided.

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| Name of Client: (Last, First, Middle Initial) | Name of Parent: (If Applicable) | Date of Birth: | |
| Street Address: | City: | State: | Zip Code: |

**CLIENT RELEASE AND SIGNATURE**

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| 1.  **I Hereby Authorize:** | |  | |  |
| Name of Person/Agency: Lakeside Center for Behavioral Change, PC  \_\_\_ Renae Reinardy, Psy.D \_\_\_ Kristin Weber, MA, LPCC \_\_\_ Chelsey Strand, LCSW | | |  |  |
| Street Address: 1450 25th Street South | City: Fargo | State: ND | | Zip Code: 58103 |
| 2. **To Disclose to and/or Obtain Information From:** | |  | |  |
| Name of Person/Agency to Receive Information: | |  | |  |
| Phone and/or Fax: | |  | |  |
| Street Address: | City: | State: | | Zip Code: |
| 3. The Following Information Is Requested: (Check Each Purpose)  \_\_\_ Psychological Evaluation \_\_\_ Progress Notes  \_\_\_ Discharge/Treatment Summary \_\_\_ Summary of Social History  \_\_\_ Diagnosis \_\_\_ Treatment Planning  \_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  | |  |
| 4. The Information Identified Above Will Be Used For: | |  | |  |
| 5. This Authorization to Disclose Information Remains in Effect Until: (Up to 1 year) | |  | |  |
| OR: (Specific Event Terminating Operation of the Release) | |  | |  |

**CLIENT CONSENT:**

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| This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Outpatient Services Contract for further description of privacy rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed in writing, information may be disclosed under this authorization in any form or medium, including oral, written, or electronic transmission. | |
| Signature of Client: | Date: |
| Signature of Parent/Guardian or Custodian (if needed and Relationship): | Date: |
| Signature of Witness (if needed): | Date: |