LAMPOST
WELLNESS CENTERS

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize Lampost Wellness Centers to receive from/disclose to:

_____ _____
Name of Information Contact **Phone Number**

_____, _____, _____, _____.
Street Address **City** **State** **Zip Code**

The following information (***Client to initial areas of approval***):

Evaluation Results	[ ]
Treatment Progress	[ ]
Attendance	[ ]
Medical Information	[ ]
Lab Reports	[ ]
Financial Information	[ ]
Any and All Information	[ ]
Other: _____	[ ]

The purpose of the disclosure authorized is for:

EAP Involvement	[ ]
Legal Involvement	[ ]
Continuity of Care	[ ]
Family Participation	[ ]
Other: _____	[ ]

I understand that my treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R Part 2, and the Heath Insurance Portability and Accountability Act of 1996 (HIPPA) and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (*please note a date for expiration*):

90 Days Post Termination (***Client to initial approval***): [ ]
Other: _____ (***Client to initial approval***): [ ]

Client Signature: _____ Date: ____ / ____ / ____

Witness: _____ Date: ____ / ____ / ____

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