Lighthouse Mental Health Group, PLLC.

Release of Patient Information **Date: _____/_____/_____**

Patient Name: _____ Date of Birth_____

I am authorizing Lighthouse Mental Health Group to:

- Release to _____ or Receive from _____ (Check one or both)

Name/Entity: _____

Address: _____

Phone: _____

Fax: _____

Reason for release of patient information: ☐ Medical Records ☐ Coordination of Care ☐ Change Providers

Other:_____

_____

Begin Request date _____/_____/_____ End date _____/_____/_____.

The date, extent or condition upon which this authorization expires is to not exceed 12 months, unless indicated above. I understand I may recant this authorization at any time by written notice.

I understand that this authorization may include information regarding services and treatment received by Lighthouse Mental Health Group and staff, including treatment and testing for drug or alcohol abuse. This authorization is valid for the dates listed above unless otherwise indicated. I hereby release Lighthouse Mental Health Group and its personnel from all legal responsibility that may arise from the act that I have authorized above. Lighthouse Mental Health Group is not responsible for completeness, legibility or omissions used by the copying of any medical records from another institution.

_____

Signature of patient or Legal Representative

_____

Printed Legal Representative

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