**Lake Norman** Family Therapy, PLLC

# *Authorization to Exchange Information*

| CLIENT NAME | SSN | DATE OF BIRTH |
| --- | --- | --- |

I do hereby give permission to Lake Norman Family Therapy or any of its subsidiaries or affiliates and staff performing services in connection with my treatment to EXCHANGE INFORMATION with the following providers:

PLEASE LIST INFORMATION FOR DOCTOR, TREATMENT PROVIDER, SCHOOL PERSONNEL, AND/OR INDIVIDUAL BELOW:

| NAME |
| --- |
| ADDRESS |
| TELEPHONE |
| FAX |

FORM IN WHICH INFORMATION SHOULD BE RELEASED: (PLEASE INITIAL ALL THAT APPLY)

______ ORAL ______ PHOTOCOPY ______ WRITTEN ______ EMAIL ______ TWO-WAY EXCHANGE ______ OTHER (SPECIFY):

INFORMATION TO BE DISCLOSED: (PLEASE INITIAL ALL THAT APPLY)

______ MY MENTAL HEALTH RECORD IN ITS ENTIRETY; OR
______ ONLY THE FOLLOWING INFORMATION (PATIENT MUST INITIAL EACH ITEM TO BE RELEASED):

______ TREATMENT PLAN
______ NAME OF NEW TREATMENT PROVIDER
______ PROGRESS REPORT ON MY NEW TREATMENT
______ MEDICATION
______ TREATMENT RECOMMENDATIONS
______ EXPECTED LENGTH OF TREATMENT
______ ATTENDANCE RECORDS ONLY
______ DIAGNOSIS/ASSESSMENT
______ OTHER (SPECIFY ANY RESTRICTIONS): ______________________________

PURPOSE FOR DISCLOSURE: (PLEASE INITIAL ALL THAT APPLY)

______ TO PERMIT CONTINUITY OF CARE
______ TO ENABLE MY EMPLOYER TO MAKE A DETERMINATION ON MY EMPLOYMENT STATUS (INCLUDING DISABILITY LEAVE)
______ TO PERMIT COORDINATION AND COLLABORATION OF CARE
______ OTHER: ______________________________

I understand that information received by Lake Norman Family Therapy may become part of my mental health record. At any time, I may revoke this consent orally or in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent will be in effect until my chart is closed with Lake Norman Family Therapy.

SIGNATURE OF CLIENT DATE

SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR OR OTHER AUTHORIZED REPRESENTATIVE (WHEN REQUIRED) DATE

SIGNATURE OF WITNESS DATE

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFE Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse member.