FLORIDA LIGHTHOUSE
COUNSELING CENTER

Authorization for Release of Information

Client Name: _____ **Date of Birth**: _____

In order for Florida Lighthouse Counseling Center (FLCC) to disclose privileged and/or confidential information regarding a Client (except as described in the Notice of Privacy Policies/HIPPA Consent), in most cases, we must have the Client give "express and informed consent" to such disclosure. "Express and informed consent" means consent which is given voluntarily, in writing, by a competent person, after sufficient explanation and disclosure of what is being authorized and for that purpose, enabling the person to make a knowing and willful decision without any element of force or deceit. If you have any questions about this authorization, please contact our office at (786) 281-7681.

I hereby authorize the use or disclosure of protected health information as follows:

- **Persons authorized to make Disclosure:**
  _____
- **Person authorized to receive Disclosure:**
  _____

For the following purpose

	Coordination of psychiatric treatment		**Housing documents**
	Coordination of medical treatment		**Department of Children & Families**
	Coordination of case management services		**Immigrations & Naturalization Services**
	Legal Coordination		**Social Security Administration**
	Communication with School/Academic Info		**Law Enforcement**
	Other:		**Other**

Expiration Date: This Authorization expires **ONE (1) YEAR** from the date it is signed **OR** if it is revoked as described below.

Revoking this Authorization: I understand I have the right to revoke this authorization in writing at any time. I understand that information disclosed before an authorization is revoked may not be retrieved. It is understood that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information. Most health care providers and all health benefit places must follow federal rules protecting the privacy of health information. However, these rules do not apply to other organizations.

I release Florida Lighthouse Counseling Center from any liability resulting from information being released, received from, or exchanged with the above mentioned individual and/or entity.

_____

Client Name **Signature** **Date**