LIGHTHOUSE COUNSELING SERVICES
325 Forest Grove Drive, Suite 201
Pewaukee, WI 53072 **www.lighthousecounselors.com**

CLIENT RELEASE OF INFORMATION

THIS FORM MUST BE COMPLETED TO AUTHORIZE THE RELEASE OF CLIENT INFORMATION TO ANY THIRD PARTY.

PATIENT NAME/DOB: _____

I hereby consent to the disclosure of the specific information listed in this document.

By and between: _____ at Lighthouse Counseling Services
(therapist name)

To and between: _____
(name of person)

_____
(address)

_____ _____
(phone) (fax)

The purpose or need for this disclosure is:

_____

I understand that the specific type of information to be disclosed includes diagnosis, prognosis and treatment for mental health including client information, financial information, informed consent, psychosocial assessment, mental status, treatment plans, staffing information, group notes, progress notes, discharge summary and any other information found in the complete client record.

Type(s) of information **NOT** to be disclosed (if any) include:

_____

This consent expires on the following date, condition or event. If none provided, this consent will expire one year from date of signature. I retain the right to revoke this consent via written request at any time. _____

_____
Patient or Authorized Representative's Signature (please indicate relationship to client)

_____
Date Signed

_____
Witness Signature