

## Lightship Family Counseling, LLC

24 Battle Street, Suite 2A, Somers, CT 06071

Phone: 860-331-9548 Fax: 860-969-2939

Secure Email: Cass@LightshipFC.com

lightshipfamilycounseling@gmail.com

### **AUTHORIZATION TO OBTAIN/DISCLOSE INFORMATION TO/FROM**

I hereby authorize Lightship Family Counseling, LLC to: (check one or both)

Disclose (share/send/allow access to) information about me and my medical/service/educational records.

Obtain (receive/request/obtain access to) information about me and my medical/service/educational records.

To/From: Name and address of third-party organization or individual  
(DO NOT ENTER CLIENT INFO HERE):

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

The information that is obtained/disclosed/accessed might include my service, treatment and/or educational information related to my diagnosis or treatment of my psychiatric disabilities, substance misuse disabilities, medical/dental conditions, or my genetic or HIV-related information. The information may be obtained/disclosed in verbal, written, and/or electronic format.

The purpose(s) of this disclosure is/are as follows (Please check ones you consent to share)

Treatment planning, communication, coordination

Discharge planning and referral

Court related or legal.

Disability determination or re-determination

Educational/IEP Planning

At request of the individual (no statement of purpose necessary)

Other (specify) \_\_\_\_\_

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Optional Section: Please describe any information which you would like Lightship Family Counseling, LLC NOT to disclose about you: \_\_\_\_\_

I understand that:

Under the applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may not be protected by federal privacy regulations.

- I may revoke this authorization in writing at any time but contacting Lightship Family Counseling, LLC at 860-331-9548, except that it will not have any effect on actions taken by Lightship Family Counseling, LLC or the recipient organization before it received my written revocation/restriction request.
- I may receive a copy to inspect the information to be used or disclosed by this authorization.
- I may refuse to sign this form and my refusal to sign this authorization will not jeopardize the right to obtain present or future treatment.
- Confidential HIV-related information that may be disclosed includes whether the client has been counseled regarding HIV, has been the subject of an HIV test, or has HIV, HIV related illness or AIDS, and could include information pertaining the client's spouse, sexual partner, or person with whom the client shared needles or syringes.
- If the client is a minor (age 17 and under), any disclosure of drug and alcohol misuse records, outpatient mental health records for treatment provided with the minor's consent only under 19a-14c, and/or HIV-AIDS-related information requires the consenting signature of the minor client below. Without such signature, Lightship Family Counseling, LLC will not disclose such records or information to the third party named above.

This authorization will expire on (one year from date of signed or when revoked in writing by client)

### Authorization to Disclose/Obtain/Access Information

By signing below, I acknowledge that I have read and understand this authorization. My signature below serves as attestation to the fact that I am the client, or I am the legal guardian of the child whose health information I am authorizing disclosure of.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Date

Mailing Address: P.O. Box 1258 Somers, CT 06071

[www.lightshipfc.com](http://www.lightshipfc.com)

Last Updated: 2/28/2024

CT LMFT: 001730

MA LMFT: LMFT10000065

FL Registered Telehealth Provider: TPMF304