The Lincoln Therapeutic Partnership (LTP)
Authorization to Release Information

I, _____, Authorize _____

Name of Client — Name and Title

_____ _____

Street Address — Organization

_____ _____

City, State, Zip Code — Street Address

_____ _____

Home Phone — Date of Birth — City, State, Zip Code

_____ _____

Social Security # — Phone # — Fax #

and Lincoln Therapeutic Partnership **(LTP)** to release the following information to each other: Verbal _____ In Writing _____

LTP will release from client's records:		Requested from above named person or organization	
___ Alcohol/Drug Use Info	___ Progress Records	___ Alcohol/Drug Use Info	___ Progress Records
___ Attendance	___ Psychiatric Assmt	___ Attendance	___ Psychiatric Assmt
___ Diagnosis	___ Psychological Assmt	___ Diagnosis	___ Psychological Assmt
___ Treatment Summary	___ Social History	___ Treatment Summary	___ Social History
___ Initial Assessment	___ Treatment Plan	___ Initial Assessment	___ Treatment Plan
___ Medications	___ Other	___ Medications	___ Other
___ Psychosexual Assessment	_____	___ Psychosexual Assessment	_____

If record is for substance abuse, patient must sign, including minors. Do not leave blanks on either side. Write in "NONE" or cross out those that do not apply.

Purpose of Disclosure(s):

___ Comply with Order of the Court
___ Response to Referral Source
___ To Assist with Payment
___ Treatment of Patient/Client
___ Other _____
___ At the Request of the Client

This authorization for release of information may be revoked by notifying, in writing, the Director at LTP, 113 Lincoln Way East, Mishawaka, IN 46544. However, it is understood that when a client/legal guardian revokes this authorization, LTP is not liable for documents sent in the time between authorization and revocation, documents that do not require an authorization, or release where the legal authority has changed. Unless another date is specified, this release will expire sixty (60) days after signing consent. The information used or disclosed may be subject to redisclosure by the person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Other expiration date authorized by the client/legal guardian _____

Or Ninety (90) days post discharge (please initial) _____

_____ _____

Signed — Date

_____ _____

Sign - Legal Guardian or Parent of Minor — Relationship

_____

Witness

When sending information to LTP, send to:

Attn: _____
Lincoln Therapeutic Partnership
113 Lincoln Way East
Mishawaka, IN 46544

Note: A copy of the following statement must accompany all material released by LTP.

Notice to recipient of LTP information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by 42CPR 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 patient.

_____ A copy of this form has been offered to me.
[Initials]