44 DiAuto Drive Randolph, MA 02368
Phone: 781.885.7252 **Fax:** 781.885.7256

NOTIFICATION of TREATMENT

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This letter is to inform you that the individual named below is receiving mental health treatment services

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to: *please fax information if possible to* (781) 885-7256

Name: LBD Counseling & Consulting Clinic

Address: 44 DiAuto Drive

City: Randolph State: MA Zip Code: 02368

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Mental Health Services, Neuropsychological Testing, Psychiatry, Substance Abuse Treatment, Drug and Alcohol Testing, Psych Testing, Psychopharm, Developmental Testing, Inpatient Treatment, Preventive Medicine, Internal Medicine.

☐ Yes ☐ No I authorize the release of my treatment at LBD Clinic by my Primary Care Physician.

☐ Yes ☐ No I authorize the release of any records regarding HIV treatment.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

Legal Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER DISCHARGE FROM RECEIVING SERVICES FROM LBD Clinic