LIGHTHOUSE RECOVERY CENTER
Authorization to Exchange/ Release Information

I, (Name of Resident) ______________________________hereby authorize the

Lighthouse Recovery Center INC.

To exchange or release confidential information regarding my treatment and recovery with

____
Name

____
Organization

____
Address City State Zip Code

This Authorization permits the release/exchange of the following information:

______ Any and All Information Necessary
______ Diagnosis
______ Clinical Test Results
______ Chemical Abuse/Dependency Report
______ Other____
______ Clinical Test Results
______ Summary of Treatment
______ Dates of Treatment

This release is for the following reason(s) (be specific)

____
____
____.

This Authorization will expire one year from the date of your signature.
I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

______________________________ ____________________ _____________
Signature of Guest Date Soc. Sec. # D.O.B.

____
Signature of Witness Date

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+1 812-642-5105 (FAX)

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Washington In, 47501

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1276 East 250 North
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Women' Facility
311 East Main Street
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