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Lisa Lounsbury
MA, LMFT, ATR-BC
Licensed Marriage & Family Therapist
Board Certified Art Therapist
Executive Director

Authorization for Release of Confidential Mental Health Information

Client Name: _____Date Of Birth: _____

Address:_____

By signing this form, I authorize the disclosure and use of health information as described below for continuity of care purposes.

Name of facility and/or provider who may receive (and/or disclose) this information:
Art Lab Rx, L.L.C. (address below) / Lisa M. Lounsbury, MA, LMFT, ATR-BC
Licensed Marriage & Family Therapist, Board Certified Art Therapist

Name of facility and/or provider who may disclose (and/or receive) this information:

Facility/Name: _____

Provider's Role/Title: _____

Address: _____

Phone: _____

At the request of the individual, the following information may be released/disclosed:

- Behavioral (Mental) Health Records and/or Chemical Health Records: This may include assessments, treatment plan, care notes, and/or discharge summary.

I understand this information will be disclosed to the above person, organization, or agency from records whose confidentiality is protected by Federal Laws (42 CFR Part 2) and by Minnesota Statutes. I also understand that I may revoke this authorization at any time by giving written notice to Art Lab Rx, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire one year from the date of signing.

I understand that my clinician generally may not condition psychological/psychiatric services upon my signing an authorization unless the psychological/psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

Signature of Client or Client's Representative: _____*Date:* _____

Signature of Parent or Guardian (if minor): _____

Please print representative's name: _____

*Representative's relationship to client:*_____

Rev 05/28/2019