Lifespan Behavioral Health Services

Taking Steps Together

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

If patient is 18 years or older, form must be completed & signed by patient. If patient is under 18 years of age, form must be completed & signed by parent/guardian.

Patient Information

Patient Name: _____ Patient DOB: _____

Information to be Disclosed to:

I, the undersigned, hereby authorize Lifespan Behavioral Health Services PC

☐ to **release** copies of medical records to: ☐ to **obtain** copies of my medical records from:

☐ to **speak** with regarding my medical record:

_____
Name of Person/Organization

_____
Address

_____
Telephone/Fax

Reason for Disclosure

☐ Further Medical Care/Specialist ☐ Insurance ☐ Attorney ☐ Disability ☐ School ☐ Personal Use

☐ Other (please specify): _____

Information to be Disclosed (check appropriate box(es))

☐ Only information related to (specify) _____

☐ Only the period of events from _____ to _____

☐ Other (specify) (Billing, Scheduling, etc.) _____

☐ Entire Record

If you would <u>NOT</u> like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (other than Psychotherapy Notes)

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

Signature

This authorization will expire within 1 year from the date of signature. I understand that I may revoke this authorization by submitting written notice of revocation to Lifespan Behavioral Health Services PC.

_____ _____

Signature of Patient (if 18 years or older) or Parent/Guardian Date

_____ _____

Printed Name Relationship to Patient

_____

Forwarding Address (if applicable)

Office Use Only PID: _____ Received by and Date: _____