Lifespan Behavioral Health Services

Taking Steps Together

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Patient DOB:** _____

Information to be Disclosed

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): _____

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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 NOT 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

Signature

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

_____

Signature of Patient **Date**

_____

Printed Name **Relationship to Patient**

_____

Forwarding Address (if applicable)