Authorization for Use or Disclosure of Protected Health Information

Name of Patient	______________________________		
Date of Birth	__________ SS# ______________	Medical Record #	__________________
Daytime Phone #	______________________________	Evening Phone #	__________________
Address	______________________________		
City	______________ State __________	Zip Code	__________________

I hereby authorize **LifeSpring Behavioral Health** to use or disclose my protected health information as indicated below to:

Name	______________________________		
Daytime Phone #	______________________________	Fax #	__________________
Address	______________________________		
City	______________ State __________	Zip Code	__________________

FROM & TO DATES:__________________________

- ☐ ALL RECORDS
- ☐ History and Physical Exam _______________
- ☐ Lab Reports ___________________________
- ☐ X-ray Reports __________________________
- ☐ Consultation Reports ____________________
- ☐ Other ________________________________

Purpose of Disclosure:

- ☐ Changing Clinicians
- ☐ Continuing Care
- ☐ At my (client) request
- ☐ Workers' Compensation
- ☐ Other _______________________________
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

X____________________________________ _______________

Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying in writing the office of **LifeSpring Behavioral Health at 1400 Woodloch Forest Dr., Suite 575, The Woodlands, TX 77380**, and this authorization will cease to be effective on the date notified except to the extent that action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy regulations. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payments for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. Upon request, I understand that I may receive a copy of this form, after I sign it.

By signing below, acknowledge that I have read and understand this Authorization.

_____________________________ __________ OR ____________________________________ __________

Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

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Relationship to Patient