LifeSpring
BEHAVIORAL HEALTH
1400 Woodloch Forest Drive, Suite 575, The Woodlands, TX 77380
Office: 281-528-1523 Fax: 281-719-0491

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____hereby authorize LifeSpring Behavioral Health to use or disclose my protected health information described below to/from:

Name _____

Address _____

City, State, Zip _____

Phone _____ Fax _____

Email _____

This authorization includes the following dates: _____ All Dates _____ From _____ To _____

This authorization includes my complete health records. Please check any records that should NOT be included:

_____ Mental Health _____ Communicable Diseases (HIV, AIDS, etc)

_____ Alcohol/Drug Abuse Treatment _____ Psychotherapy Notes

This authorization shall be in force until revoked. I understand I have the right to revoke this authorization at any time, in writing, to LifeSpring Behavioral Health, 1400 Woodloch Forest Drive, #575, The Woodlands, TX 77380. This authorization is not effective to the extent that a person or entity has already acted in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal privacy regulations.

My health care and payments for my health care will not be affected if I do not sign this form. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment, in emergency situations and/or is required by law.

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

_____ _____
Signature Printed Name

_____ _____
Date Relationship