LAKESIDE
BEHAVIORAL HEALTH SYSTEM

Patient Label

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Birth Date:_____
Maiden/Prior Names:_____ Current Phone #: _____
Current Address:_____

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody
☐ Academic ☐ Legal Investigation ☐ Other:_____

Dates of Service Requested:_____

I **authorize the release of the following:**

☐ Aftercare Packet (Discharge Plan Parts 1, 2 & 3, Discharge Safety Plan, Medication Reconciliation, Advance Directives)
☐ History and Physical
☐ Alcohol and Drug Abuse Treatment Records
☐ Physician's Orders
☐ Discharge Summary
☐ Psychiatric Evaluation
☐ Lab/Diagnostic Reports
☐ Progress Notes
☐ HIV Test Results and AIDS Treatment Records
☐ Other:_____

To be released by: ☐ Lakeside Behavioral Health System (Ph: 377-4700) (Fax: 373-0971)

☐ _____ (____)_____ _____
Agency/Name Telephone Number Address City State Zip Code

To be released to:

☐ _____ (____)_____ _____
Agency/Name Telephone Number Address City State Zip Code

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire one year from signature date)

Date authorization revoked: _____ **Signature of patient/guardian: _____**

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. You right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

This form must be completed in full before signing:

_____ _____ _____
Patient's signature Parent/Legal Guardian signature (if applicable) Relationship to Patient

_____ _____
Witness signature/Credentials Date Signed

This authorization is intended to allow **Lakeside Behavioral Health** to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.