LOTT BEHAVIORAL HEALTH, LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

First and Last name
Patient Name

Date of Birth
Date of Birth

I hereby freely and voluntarily authorize Lott Behavioral Health, Ltd. to receive or disclose information from/to:

Person/Facility Name: Name(s) of person, provider, or facility we can exchange information with

Phone: _____ Fax: _____

Address: put as much info as you have - phone, fax, address
Street City State Zip

The purpose of this disclosure is: ☐ disability ☐ insurance ☐ personal } choose one or more
☐ transfer of care ☐ other: _____

By checking the spaces below, I specifically authorize the release or disclosure of the following information and/or records, if such information and/or records exist:

☒ ENTIRE RECORD, *or choose from the following:*

____ Progress Notes	____ Neuropsychological Test Report	____ Physician Orders
____ Laboratory Reports	____ Psychiatric Evaluation/Assessment	____ Billing Information
____ Medication Record	____ Psychological Test Report	____ Treatment Plan
____ Discharge Summary	____ Other (Specify) _____	

Select at least one above - "Entire Record" is the simplest one.

Approximate Treatment Dates Between 1/1/1990* and 1/1/2035*
* make the date range as large as possible - must include dates of info.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that this information may include details from my history about HIV, mental health, alcohol and other substance use, and genetic test results, and I consent to this disclosure. I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Lott Behavioral Health, Ltd. The revocation will need to be signed by me and be witnessed by a person who can attest to my identity. Any revocation will take effect when Lott Behavioral Health, Ltd. receives the revocation, except to the extent that Lott Behavioral Health, Ltd. has already relied on the authorization. I understand I have the right to inspect or copy any information to be used or disclosed under this authorization. I understand that no person or agency to whom any information is disclosed may re-disclose the information unless I specifically consent to re-disclosure.

This authorization will terminate on _____ or if no date is marked, it will automatically terminate five years from the date it was signed.

Patient Signature: SIGN HERE Date: DATE

Parent/L.G. Signature: <only if you are <18 or if you have a guardian.> Date: <DATE>

Witness Signature: MUST have signature of a witness who can identify you Date: DATE