LOTT BEHAVIORAL HEALTH, LTD.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ _____
Patient Name Date of Birth

I hereby freely and voluntarily authorize Lott Behavioral Health, Ltd. to receive or disclose information from/to the following physician/person/facility/entity:

Name(s): _____

Phone: _____ Fax: _____

Address: _____
Street City State Zip

The purpose of this disclosure is: _____

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
____ Progress Notes
____ Laboratory Reports
____ Medication Record
____ Discharge Summary
____ Educational Evaluation
____ Neuropsychological Test Report
____ Psychiatric Evaluation/Assessment
____ Psychological Test Report
____ Other (Specify) _____
____ Scheduling
____ Billing Information
____ Refills

Approximate Treatment Dates Between _____ and _____

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 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: _____ Date: _____

Parent/L.G. Signature: _____ Date: _____

Witness Signature: _____ Date: _____