

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:

Provider/Facility Name: _____

Phone: _____

Fax: _____

Address: _____

Street

City

State

Zip

The purpose of this disclosure is: disability insurance personal

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) _____

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 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: _____

Date: _____

Parent/L.G. Signature: _____

Date: _____

Witness Signature: _____

Date: _____