Lott Behavioral Health

Authorization for Release of Medical Records

_____ _____/_____/_____

Patient First & Last Name ***Patient Date of Birth***

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

Person/Facility Name: _____

Phone: _____ Fax: _____

Address: _____

Street *City* *State* *Zip*

The purpose of this disclosure is (**select one or more**):

___ coordination of care ___ personal ___ disability ___ insurance

___ transfer of care ___ other _____

(such as credit card authorization)

By **checking the space(s) 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
___ Laboratory Reports
___ Medication Record
___ Discharge Summary
___ Neuropsychological Test Report
___ Psychiatric Evaluation/Assessment
___ Psychological Test Report
___ Other (Specify) _____
___ Physician Orders
___ Billing Information
___ Treatment Plan

Approximate Treatment Dates Between _____/_____/_____ and _____/_____/_____

(please make date range as far into past and future as possible)

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. Unless otherwise revoked, this authorization will terminate on any future date of my choosing that I write here **_____/_____/_____ or if left blank five years from the date signed**.

(insert future treatment date from section above to make ROI valid longer than 5 years)

Patient Signature: _____ Date: _____/_____/_____

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

ONLY REQUIRED for patients under age 18, PLUS different witness signature below (can be the other parent)

Witness Signature: _____ Date: _____/_____/_____

REQUIRED for ALL patients, (for patients under age 18, someone other than parent signing above; can be other parent)