LEAD Behavioral Health

Authorization for Disclosure of Protected Health Information

Patient Name: ____ Date of Birth: ____________________

Social Security Number: ________________________________ Date of Request: ____________________

____
Name of Physician and/or Firm Receiving Information

____
Address City State Zip Code

The information to be released includes (check all that apply):

☐ Diagnosis ☐ Medical Record ☐ History & Physical ☐ Lab Work

☐ Progress Notes ☐ Assessment ☐ Other: ____________________________

LEAD Behavioral Health and/or administrative and clinical staff are hereby authorized to disclose Protected Health Information (PHI) to the above named physician or firm. This authorization includes the release of records with documentation of treatment or follow-up care, pertaining to mental health, alcohol and/or drug abuse or overdose, if applicable, within the categories specified above.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to this office at . 516 W. Shaw, STE. 200, Fresno, CA 93704. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. My physician or therapist will not condition my treatment on whether I provide authorization for the request use or disclosure except if health care services are provided to me solely for the purpose of creating (PHI) for disclosure to a third party.

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by Federal confidentiality rules. **It is the policy of LEAD Behavioral Health . to not release records directly to the patient.**

If this release is signed by someone other than the patient/client (i.e. Parent, Guardian or Legal Representative), state your name and legal relationship to the patient/client:

______________________________ ______________________________ ____________
Name of Parent, Guardian or Legal Representative Signature Date Signed

State relationship and authority to sign on behalf of the patient: ____

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REVOCATION OF AUTHORIZATION

(Only sign this area if you wish to revoke an authorization that is already in place)

I hereby revoke this Authorization for Disclosure of Protected Health Information

______________________________ ______________________________ ____________
Name of Patient, Legal Representative Signature Date Signed

If signed by, other than Patient, state relationship and authority to do so: ____

Revised: February 2011