



Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request

An authorization for use or disclosure of protected health information may not be combined with any other document to create a compound authorization. Please complete a new Authorization for Use and Disclosure of Health Information and Patient Access/Copy Request Form.

Name:	Date of Birth:	Phone:
Address:	City:	State: Zip Code:

The said patient above has **declined** to complete this form.

I hereby freely and voluntarily authorize Lone Star Behavioral Health to **RELEASE** **OBTAIN** the following **TO** **FROM**

Recipient Name:	Relationship:		
Address:	City:	State:	Zip Code:
Phone:	Fax (healthcare provider only):		

Preferred Delivery Method: Fax Mail Pick-up

My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulation (42 CFR part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations.

Purpose of Disclosure: Continuum of care Personal Use Legal Other (specify): _____

Covering the period of healthcare from: Specific Date(s): _____ to _____

The information to be released or obtained includes:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Discharge Instructions	<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Other (specify): _____

I understand that I have the right to inspect and copy any written information disclosed and the right to revoke this consent at any time by giving written notice to Lone Star Behavioral Health. I UNDERSTAND REQUESTED COPIES WILL BE SUBJECT TO A REASONABLE FEE.

Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits. This authorization will expire in 90 days. I have read and understood the information above and with my signature below: authorize the recipient, use and disclosure of the information described in this document for the limited purposes identified herein.

**PATIENT MUST SIGN RELEASE REGARDLESS OF AGE IF ALCOHOL AND/OR DRUG TREATMENT IS INVOLVED. **

Patient or Personal Representative Signature Date

Printed Name of Patient, Guardian, Authorized Representative (if applicable) Date

Printed Name of Witness Signature of Witness Date

To revoke this authorization, sign and date in the space provided below. By signing this revocation, I understand that this revocation will be effective today, except to the extent that Lone Star Behavioral Health has already relied upon by authorization to use or disclose my health information as described in the Notice of Privacy Practices.

Signature Date Witness Date