LIFTING STIGMAS
CHANGING LIVES
OUTPATIENT MENTAL HEALTH CLINIC • COMMUNITY OUTREACH ORGANIZATION

Authorization to Use and Disclose Protected Health Information

NOTICE – PLEASE READ: I understand that each authorization signed below will remain in effect for **365** days after I sign and date the form. Each authorization may be withdrawn at any time in writing except to the extent that action has already been taken. Upon receipt of written revocation, further release of information shall cease immediately, except as allowed by law. Recipients of this information are forbidden to re-disclose this information without my specific authorization.

I understand that if I have authorized Lifting Stigmas and Changing Lives(LSCL) to disclose my information to persons who are not required by Federal or State law to keep the information confidential, these persons receiving my records may disclose my protected health information to others without my consent or authorization. LSCL will not be responsible for the misuse or re-release of information by another individual, agency, or entity.

Notice To Recipient Of Information: This information has been disclosed to you from records protected by Federal Confidentiality Rules. The Federal Rules prohibit the recipient of the protected health information from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Client Name :_____Date of Birth:_____/_____/_____

I hereby authorize the Lifting Stigmas and Changing Lives to:

❏Disclose information ❏Request Information ❏Exchange Information

With Name of Person or Entity:_____

Address_____

Telephone/ Fax:_____

INFORMATION TO BE USED/DISCLOSED/REQUESTED

Check the boxes of items needed:

	Diagnostic Assessment		Psychological Evaluation Reports		Treatment Plan/ISP
	Progress Notes		Psychiatric Evaluation		Other Social History
	Physician's Orders		Court Reports/Records		Medication Records
	School/Consultation		Laboratory Reports		Employment/Records / Reports
	HIV/AIDS Status		Drug and Alcohol Addiction Records		Recent Physical Exam

Other (CLEARLY SPECIFY)_____

Purpose for Disclosure ❏Assist in Treatment Planning ❏ Continuity of Care ❏Other

I understand that I may withdraw this consent at any time in the future as explained above and that this consent will expire in 365 days from the dates signed below, unless otherwise specified.

This consent will expire on _____/_____/_____ OR Upon discharge from services