Lamb Behavioral Health Center, LLC
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Authorization to Obtain Information/Release of Information

This form, when completed and signed by you, authorizes Lamb Behavioral Health Center, LLC to release protected information from your clinical record to the person you designate.

Patient name: _____ Date of birth: _____

I authorize my psychologist/counselor or delegated staff member from Lamb Behavioral Health Center to obtain/release the following: (Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

___ Pertinent treatment information: ___ Including psychotherapy notes
___ Including drug/alcohol treatment
___ Results of psychological assessment ___ Account information (billing, scheduling)
___ Other (Your description should be as specific and detailed as possible.)

_____

This information should only be obtained from/released to the following: [Provide name (or function), institutional affiliation, and address of person from/to whom the information is to be obtained/released.]

_____

_____

I am requesting my mental health provider to obtain/release this information for the following reasons, and subject to the following limitations:

_____

This Authorization shall remain in effect until _____ (fill in expiration date) or until revoked (fill in an event that relates to the individual or the purpose of the use or disclosure). However, I understand that this Authorization does not permit disclosure of my future health care given more than 1 year from the date of this Authorization (unless this is for disclosures to insurance companies). If this Authorization does not contain an expiration date, the Authorization expires 1 year from the date of my signature.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Lamb Behavioral Health Center. My authorization will not be effective to the extent that the provider has taken action in reliance on my authorization, or if this authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that my mental health provider generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient or Patient's Legal Guardian Date

_____
Description of Legal Guardian's relationship to or authority to act for the patient