LPS Behavioral Health, LLC
Authorization to Release Confidential Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my psychologist/physician/clinician, _____ and/or his or her administrative and clinical staff to release the following information in my file at this office:

_____Assessment and diagnostic Information
_____Progress notes
_____Discharge/termination summaries
_____Other information (specify):

_____

_____

This information should only be released to **LPS Behavioral Health, LLC, 3630 Meadows Drive, Martinsville, Indiana 46151 (Fax: 800.596.3681)**.

I am requesting my psychologist/physician/clinician to release this information for the following reasons: ("***at the request of the individual***" *is all that is required if you are my patient and you do not desire to state a specific purpose*.)

_____

This authorization shall remain in effect until _____ or until _____

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist/physician/clinician generally may not condition psychological/health services upon my signing an authorization unless the psychological/health 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 redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____
Signature of Patient Relationship Date

Patient's Address:
_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

(**HIPPA Compliant form,** provided by *LPS Behavioral Health, LLC*, 3630 Meadows Drive, Martinsville, Indiana, 46151. Tel: 765.318.1225)