PATIENT AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Laurel Ridge Treatment Center, 17720 Corporate Woods Drive, San Antonio, Texas 78259
Phone: (210) 491-9400 Fax: (210) 491-3578

_____ _____
(Patient Name) (Date of Birth) (Date of Hospitalization (s))

I hereby freely and voluntarily authorize Laurel Ridge Treatment Center to…
(Check one) ____ Release/Disclose records of my health information to:
____ Obtain records of my health information from:

_____
(Individual, Facility, Organization) (Telephone Number)

_____
(Address) (Fax Number)

_____
(City, State, Zip)

The purpose for this disclosure is: _____
The information to be released includes:

☐	Complete Record	☐	Treatment Plans
☐	Admission Psychiatric Evaluation	☐	Discharge Summary
☐	History and Physical	☐	Verbal exchange of information
☐	Psychological Testing	☐	Other _____

My medical records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law.

I understand that I have the right to revoke this authorization at any time by giving written notice to the Laurel Ridge Treatment Center Privacy Officer, except to the extent that Laurel Ridge Treatment Center has already taken action in reliance on it. This authorization will expire in **180 days** or as otherwise specified herein: _____; whichever comes first.

_____ _____
Patient Signature ***Patient must sign release regardless of age if alcohol and/or drug treatment is involved.*** Date

_____ _____
Parent/Guardian/If Authorized Representative (Describe: _____) Date

_____ _____
Witness Signature Date