Consent to Release Confidential Health Information

Patient's Name: _____ DOB: _____

I, (Name of Patient): _____

Releasing Agency: _____

Address: _____

Phone/Fax/Email: _____

To Disclose To:
Receiving Agency: _____

Address: _____

Phone/Fax/Email: _____

The following information with knowledge such release discloses the fact that the named person has received behavioral health services. The disclosure shall be limited to the following specific information (Nature and amount of information to be disclosed as limited as possible to accomplish the stated purpose or intended use):

____Medical Chart
____Psychiatric Evaluation
____Psychological Testing/Evaluation
____Medical Test(s)/ (Labs, Procedures, etc.)
____Medications

Other:_____

I understand that 1) My behavioral health records are protected by the federal Health Insurance Portability and Accountability Act (HIPPA) of 1996 and cannot be disclosed without written consent unless otherwise provided for by the regulations. The exceptions are set forth in the Notice of Privacy Practices; 2) I may revoke my consent by providing a written notice withdrawing my consent and 3) If Dr. Leslie E. Lawrence, LLC., has already discussed information in reliance on my consent, Dr. Leslie E. Lawrence, LLC., is not required to try to retrieve that information. If not earlier revoked, this consent shall automatically terminate and **expire 12 months from the date it was signed.**

_____ _____
Patient's Signature Date

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