Lifespan Behavioral Health

Taking Steps Together

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

If patient is 18 years or older, form must be completed & signed by patient.
If patient is under 18 years of age, form must be completed & signed by parent/guardian.

Patient Information

Patient Name: _____ Patient DOB: _____

Information to be Disclosed to:

I, the undersigned, hereby authorize Lifespan Behavioral Health Nevada PC
☐ to release copies of medical records to:
☐ to obtain copies of my medical records from:
☐ to speak with regarding my medical record:

_____
Name of Person/Organization

_____
Address

_____
Telephone/Fax

Reason for Disclosure

☐ Further Medical Care/Specialist ☐ Insurance ☐ Attorney ☐ Disability ☐ School ☐ Personal Use
☐ Other (please specify): _____

Information to be Disclosed (check appropriate box(es))

☐ Only information related to (specify)
_____
☐ Only the period of events from _____ to
_____
☐ Other (specify) (Billing, Scheduling, etc.)
_____
☐ Entire Record
If you would NOT like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

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Signature

This authorization will expire within 1 year from the date of signature. I understand that I may revoke this authorization by submitting written
notice of revocation to Lifespan Behavioral Health.

_____ _____
Signature of Patient (if 18 years or older) or Parent/Guardian Date

_____ _____
Printed Name Relationship to Patient

_____
Forwarding Address (if applicable)

For requests to have records sent to Lifespan Behavioral Health Nevada PC:

Preferred delivery method is via our HIPPA compliant secure Fax Number 725-715-2123

Or By Mail: Lifespan Behavioral Health Attn: Records 2401 W. Horizon Ridge Pkwy, Suite 110 Henderson, NV 89052