THE LAKEWOOD GROUP, LLC

Mental Health Services

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AUTHORIZATION TO RELEASE INFORMATION / PROTECTED HEALTH INFORMATION

I, _____ authorize _____ of
(your name) (your Lakewood Group doctor's name)
The Lakewood Group, LLC to release to and/or obtain from:

Name of individual: _____

Organization: _____

Address: _____

_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

the information regarding _____ , Date of Birth _____-_____-_____.

I, the undersigned, understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance upon it or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. In any event this consent shall expire six (6) months after the date of patient discharge from treatment, unless another date, event or condition is specified.

Optional: Specified date_____-_____-_____, or event _____ or condition_____.

I further understand that services may not be made contingent upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of your information and may no longer be protected by the HIPAA Privacy Rule.

By my signature below, I am authorizing the purpose of the release to be at the request of the individual unless otherwise stated below. I am also authorizing release of any and all protected health information unless otherwise stated below.

Optional: Purpose of release of information _____

Optional: Released information will be limited to: _____

_____

SIGNATURE: Patient: _____ Date: _____-_____-_____

OR Parent or Guardian or Personal Representative: _____

If the patient is either under age or has a guardian appointed by the court, this authorization must be signed by the patient's legal guardian. If the authorization is signed by a personal representative of the patient, a legal description of such representative's authority to act for the patient must be provided.