Lakeside Behavioral Health System
2911 Brunswick Road
Memphis, TN 38133

Ph:901-377-4700 ext. 230
Fx: 901-373-0971

Authorization for Release of Information

I, _____, do hereby authorize Lakeside Behavioral
Patient's Name
Health Systems and its affiliates to release to_____
Agency or Individual

Circle Permission to Fax: Y / N

_____
Address *Fax #*

Medical information relating to my treatment in said facility for the following purpose(s):
_____Continuing Medical Care _____Insurance/Reimbursement _____Other, Please Explain

_____
Explanation

The information released shall be limited to the following time period(s) of illness:

_____
Dates of service

Included shall be the following specific type data **(check all that apply)**:

_____History and Physical _____Discharge Data ____Labs _____ Medications

Expiration Date:

- This authorization will expire 6 months after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time. I also understand that any release of information made prior to my revocation and which was made in reliance upon an authorization shall not constitute a breach of confidentiality.

_____ I understand that my medical record will include information on diagnosis/treatment related to
Initial psychiatric or psychological conditions, drug and/or alcohol abuse, AIDS and /or HIV status. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released covered by Title 42 of the Code of Federal Regulations.

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability ct (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards). **Notice of Re-disclosure:** This information has been disclosed to you from confidential records, which are protected by Federal Law. Further disclosure of this information is prohibited without the specific written consent of the person to whom it pertains. A general authorization for this release of medical or other information is not sufficient for this purpose. **Faxing of confidential information:** The medical record is privileged and confidential. Information from a patient's record will be faxed only for urgent patient care reason in which other methods of transmission will deter further patient care or provision of needed services. The patient must authorize the fax after he/she has been informed of the risks involved in sending material by fax. **Lakeside Behavioral Health System will not be held liable for any breach of confidentiality occurring from this fax transmission.**

_____ _____/___-__-____
Patient Signature **Date** **DOB** **SSN**

_____
Witness / Guardian **Date** **Contact Phone Number**