LifePointe Counseling, LLC

Healing Hearts ✧ Restoring Hope

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

Primary Phone (☐ Home ☐ Cell): _____ **Work Phone:** _____

I, the undersigned patient or legal guardian, hereby authorize _____ verbal and/or _____ written information to be released by and to: ***(initial)*** ***(initial)***

(1) LIFEPOINTE COUNSELING, LLC PHONE: (314) 849-2120
Name of Releasing Facility/Provider

11166 Tesson Ferry Road, Suite 203; St. Louis, MO 63123 FAX: (314) 729-1953
Address

(2) _____
Name of Hospital/Clinician/Third Party Phone

_____
Address Fax

(3) _____
Name of Hospital/Clinician/Third Party Phone

_____
Address Fax

Information to be released *(please initial)*:

____ Psychiatric Evaluation	____ Psychosocial	____ Discharge & Aftercare Plan
____ Medication Record	____ Psychological Testing	____ Progress Notes
____ H&P/Labwork	____ Treatment Planning	

____ Other (specify) _____

Release of information for the following purpose(s):

☐ Treatment/Consultation ☐ Patient Request ☐ Billing or Claims ☐ Attorney
☐ Other (specify) _____

- I understand that the information released may be pertaining to: ***(Initial for release of the following information)***
  _____ Mental Health, Substance Abuse and HIV/AIDS information.
- I understand that this authorization is voluntary and that treatment by a LifePointe Counseling, LLC provider cannot be conditioned on the signing of this authorization.
- I understand there may be a charge, payable in advance, for the copying and conveyance of records released.
- I understand that this authorization can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that have taken place before I withdrew my consent.
- I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected. LifePointe Counseling, LLC and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I understand that the information which is being released is from records whose confidentiality is protected by state and federal Law.

_____ _____
Patient or Legal Representative (Description/Proof of authority to act for patient must be provided) Date

_____ _____
Witness and Title Date

Expiration Date: *This document remains in effect until written notice from the patient and/or legal representative terminating this Authorization To Release Health Information is provided.*