LIFESPAN
PSYCHIATRIC CONSULTING

Individual Authorization for the Use and Disclosure of Individually Identifiable Health Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Last (4) SSN #: _____

I have previously consented to the use and disclosure of my individually identifiable health information for treatment, payment, and health care operations without restriction.

I understand that for all other uses and disclosures, except those that do not require consent, authorization, or opportunity to object, I must sign an individual authorization for such uses or disclosures.

I also understand that, if Lifespan Psychiatric Consulting, LLC is requesting the authorization for its own use, it will not condition the treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for the requested use or disclosure.

I understand that I may inspect or copy the individually identifiable health information or protected health information ("PHI") to be used or disclosed. I further understand that I may refuse to sign the authorization.

If this disclosure will result in direct or indirect remuneration (payment) to the entity from a third party, I must receive a statement that such remuneration will result.

I hereby knowingly and voluntarily authorize:

Name:
Contact Information:

May disclose the following information to Lifespan Psychiatric Consulting, LLC: (INITIAL)

____ Medical History and Evaluation	____ Demographic Information
____ Psychological Evaluation	____ Discharge / Transfer Summary
____ Mental Health Treatment Records	____ Laboratories
____ Medication Management Information	____Alcohol and Drug Treatment Records
____ Treatment Progress Notes	____ **All of the Above**

For the following purpose(s): PSYCHIATRIC EVALUATION & TREATMENT

This authorization expires on _____

I understand that I have the right to revoke this authorization in writing unless either of the following conditions exists:

- Lifespan Psychiatric Consulting, LLC has taken action in reliance thereon.
- This authorization was obtained as a condition of obtaining insurance, and a law provides the insurer the right to contest a claim under the policy.

I understand that I must deliver a written revocation to Lifespan Psychiatric Consulting, LLC at 320 N Main Ave Suite 209, Gresham, OR 97030. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

_____ _____

Signature of Patient / Parent / Guardian / Personal Representative Date

_____ _____

Signature of Staff Witness Date

Phone 503.491.5896
Fax 888.972.9783
Web LifespanPsychiatric.com

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Gresham, OR 97030