Authorization for the Release of Protected Health Information

By completing this form, you are authorizing The Lakes Treatment Center to release your protected health information identified herein to the person or entities identified herein. You also have the right to request copies of those records. You will receive a response to your request within 15 days after we receive your request. If you want your response by mail, it will be postmarked within 15 days after we receive your request. Please reach out to Nick@lakestreatmentcenter.com if you have not received a response within that time frame. You will need to include a copy of a photo ID or other valid identification. **Send this completed form to:**

- **Email:** Nick@lakestreatmentcenter.com ; or
- **Mail:** The Lakes Treatment Center
  Attn: Records Request
  7260 O'Byrnes Ferry Rd
  Copperopolis, CA 95228
  (209) 325-8506

Your Information:		
Last Name:	First Name:	Middle Initial:
Address:	City/State:	Zip Code:
Medical Record # (if known):	Date of Birth:	
Telephone Number:	Email Address:	

Person/Organization Providing the Information:	Person/Organization to Receive the Information:
Name:	Name:
Address:	Address:
City/State/ZIP:	City/State/ZIP:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

Description of the Specific Information to be Released/Inspected:

Check Each Type of Confidential Information You Authorize to be Released/Inspected:

☐ HIV or AIDS	☐ Alcohol/Drug Information
☐ Mental Health/Behavioral	☐ Health Genetic Testing

Other:

I Am Requesting Copies of Records for the Following Dates of Service:

From Date (month/day/year):	To Date (month/day/year):

This authorization for release of the above information to the above-named persons or organizations

Expires on: _____ (will expire in one year from date signed if left blank)

How to Review/Send Requested Information:

◯ Email	◯ Fax	◯ Mail

◯ I request that a person of my choosing by allowed to inspect my records in person. You will be contacted to schedule an appointment (only available in Copperopolis, CA).

Description of the Purpose and Limitations for the Release:

The information will not be used for any purpose other than its intended use.

Identifying Information:

☐ Copy of identification attached

Type: _____ (Driver's License, DMV ID Card, Birth Certificate, Benefits Identification Card, Managed Care Card, State Or Federal Employee ID Card)

☐ Address verification attached

Type: _____ (Utility Bill, Phone Bill, Driver's License, Etc.)

If no identification is attached, your signature must be notarized.
Contact Nick@lakestreatmentcenter.com for additional information

Notarized By _____ On _____ (Date).

Notary Public Number: _____

Unofficial Unless Stamped by Notary Public

I understand that by signing this authorization:

1. I authorize the use and/or disclosure of my individually identifiable health information as described above for the purpose(s) listed. I understand that this authorization is voluntary.
2. I have the right to revoke this authorization at any time by sending a signed notice stopping this authorization to the address on page one. The authorization will cease on the date my valid revocation request is received.
3. An individual may revoke an authorization at any time, provided the revocation is in writing, except to the extend that: The covered entity has taken action in reliable thereon; or if the authorization was obtained as a condition of obtaining insurance coverage.
4. My treatment, payment, enrollment, or eligibility for benefits will not be affected if I do not sign this authorization.
5. Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or a specifically required or permitted by law.
6. If the organization or person I have authorized to receive the information is not a health plan or health care provider; the release of information may no longer be protected by federal privacy regulations.
7. I have the right to receive a copy of this authorization.
8. Records and copies obtained relating to outpatient psychotherapy care shall be returned or destroyed at the expiration date of this authorization except those obtained for treatment and diagnosis purposes.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Signature:	**Date:**