# LIGHTHOUSE PSYCHIATRY

## RELEASE OF INFORMATION (ROI) OF PROTECTED HEALTH RECORDS

| PATIENT INFORMATION | | |
|---|---|---|
| Patient Name: | Gender: [ ] Male [ ] Female | DOB: |
| Home Address: | | |

*I AUTHORIZE THE RELEASE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION BETWEEN THE FOLLOWING FACILITIES, PROVIDERS, ENTITIES/ORGANIZATION, AND/OR PERSONNEL:*

| | | | |
|---|---|---|---|
| A. | LIGHTHOUSE PSYCHIATRY<br>4001 EAST BASELINE ROAD SUITE 204, GILBERT, ARIZONA 85234<br>TMS@LHpsych.com Tel: (480) 565-6440 Fax: (480) 454-1085 | | |
| B. | [ ] MEDICAL FACILITY [ ] PERSON (family, friend) [ ] LEGAL ENTITY [ ] OTHER _____ | | |
| | Facility: | | |
| | Name: | | Relationship: |
| | Address: | | |
| | Email: | Telephone: | Fax: |

**INFORMATION RELEASED INCLUDE:**

[ ] ALL MEDICAL RECORDS [ ] TREATMENT/PROGRESS NOTES [ ] MEDICATION LIST [ ] HOSPITAL RECORDS

[ ] LAB RESULTS [ ] IMAGING RESULTS [ ] TEST RESULTS [ ] DISCHARGE SUMMARY

[ ] OTHER _____

**REASON FOR RELEASE OF INFORMATION:**

[ ] COORDINATION/CONTINUITY OF CARE [ ] TRANSFER OF CARE [ ] INSURANCE [ ] LEGAL [ ] PERSONAL

[ ] OTHER _____

| | |
|---|---|
| **DATES NEEDED: 1 (ONE) YEAR** | **IF OTHER DATES NEEDED, PLEASE SPECIFY:** |

1. I understand that my Protected Health Information may contain information relating to Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care, Psychiatric Care, treatment of alcohol/drug abuse and genetic testing.
2. I understand that my treatment from clinic is not contingent on my signing this authorization. The clinic will not deny me treatment if I do not wish to sign.
3. I understand that the information released may no longer be protected by state and federal regulations and may be redisclosed by the authorized recipient.
4. I understand I may revoke this authorization at any time by simply submitting a written request to **LIGHTHOUSE**.
5. I understand this AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED, if not revoked prior to expiration date.
6. I release **LIGHTHOUSE**, all providers and staff, from any legal liability for the release of information in accordance to the above authorization.
7. I understand a SURCHARGE rate may apply to release and distribute PHI to entity above, exception treating medical professionals and health insurance carriers. **[RATE FOR COPIES OF MEDICAL RECORDS: $25 for the first 20 pages and $0.25 per each additional page]**

By signing this form, I, the patient, authorize release of my protected health information, including a copy of my medical records, and/or a summary or narrative of my protected health information, BILATERAL communication between LIGHTHOUSE and the entity authorized above.

_____

Patient/Legal Representative Signature Date Time

_____

Legal Representative Name Relationship