Lightshare Behavioral Wellness & Recovery, Inc.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In accordance with Federal Law, 42 CFR Part 2 governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Pts 104-191, 160 & 164, 42 U.S.C. Section 132d.et.Seq.

Name of Person Served: _____ Date: _____ DOB: _____

Phone Number: _____ Contact Info: _____

This form will authorize Lightshare Behavioral Wellness & Recovery to release or receive general medical, a/substance abuse, psychiatric, psychological information from my record in accordance with Florida Statutes and Florida and Federal Administrative Rules and Regulations to/from:

Print name of Person/Agency information to be released to/received from: _____

Print address of Person/Agency to be released to/received from: _____

Telephone number of Person/Agency: _____ Fax number of Person/Agency: _____

(Initial all that apply below)

Information to be:	☐ Released	☐ Received
_____Discharge Summary		_____ Drug Screens/Lab Reports
_____Program Participation		_____Treatment Plan/Service Plan
_____ Assessments		_____HIV Information
_____ Certificate of Completion		_____ Other: _____

Purpose of Disclosure: _____

At Request of Individual: _____ or Agency: _____ (initial either as appropriate)

Type of communication authorized: (initial all that apply)

_____Verbal _____Written _____ Fax This is a Single Disclosure ☐ Yes ☐ No

Information disclosed under this authorization might be re-disclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

I understand that I have the right to refuse this authorization and that generally the program may not condition my treatment, payment, enrollment in the health plan or eligibility for benefits on whether I sign an authorization form. If this authorization is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party, and I refuse to sign the authorization, Lightshare may refuse to provide the treatment.

This authorization is subject to revocation at any time except to the extent that the agency which is to make disclosures has already taken action in reliance on it. I may revoke this authorization by providing Lightshare notification in writing of my wish to revoke the authorization. If not previously revoked, this authorization will terminate upon: _____ (enter date, event, or condition upon which this authorization will terminate) or within one year from the date of signature if no entry is made. Furthermore, this authorization will remain in effect while the person served is under an involuntary treatment order, subject to a revocation of this authorization.

I understand that revoking this authorization, before I satisfy the condition of my supervision which requires me to participate in the program will be reported to the Court/referring agency. My revocation of authorization under such circumstances could be considered a violation of the condition of my supervision.

I have received a copy of this form if requested, as recognized by my signature below:

_____ _____

Signature of Person Served Date

_____ _____ _____

Representative/Parent/Guardian Date Relationship of Representative

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited unless the person provides specific written authorization to you for the subsequent redisclosure of this information.

Revoked Date: _____ Person Served Signature: _____

Staff Signature: _____ Date: _____