Living Rationally, Inc.

Alicia Baldwin, DO
Harry Steinmeyer, PsyD, LCSW

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name ______________________ **Date of Birth** ______________________

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In one year
- ☐ In six months
- ☐ In three years
- ☐ On Date: ______________________

The person named above hereby authorizes **Living Rationally, Inc.** **to:**
Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Send health information to
- ☐ Discuss health information with
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of:

Name of Person, Provider or Facility: ______________________

Address: ______________________

____

Phone: ______________________

Fax: ______________________

Scope:

☐ All information regarding assessment, diagnosis and treatment of patient's condition, concern or disease (please specify):

____

☐ All information regarding care received by patient between the dates of:

______________________ and ______________________
Start date End Date

☐ Other information (please specify):

____

1200 Van Arsdale Street ♦ Oviedo, FL 32765 ♦ Off: (407) 754-4690 ♦ Fax: (407) 365-5104

Authorization

____
Printed Name of Patient or Authorized Representative

______________________	__________	______________________	__________
Signature of Patient or Authorized Representative	Date	Signature of Witness	Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above **must** initial and date each item. If an item is not initialed and dated, the information (if such exists) cannot be released or discussed

Initial	Date		From	To
________	________	Alcohol or Drug Use/Abuse Treatment	________	________
________	________	Mental Health Treatment	________	________
________	________	HIV Status or Treatment	________	________

The person named above has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.