



**AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
(ALABAMA)**

I, _____, authorize

(Patient Full Name)

Lighthouse Psychiatry & Behavioral Health Clinic to disclose to _____

(Name of person or organization disclosure is being made to)

the following information _____

(Specific nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to: _____

(Reason for disclosure)

_____ *(Initial)* I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

_____ *(Initial)* I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: _____

(Specification of date, event, or condition upon which express consent expires)

_____ *(Initial)* Should I decide to revoke this authorization prior to its expiration, I understand that I must do so in writing.

_____ (*Initial*) I understand that the covered entity seeking this authorization may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on whether I sign the authorization.

I understand that I am entitled to receive a copy of this authorization after it is signed.

DATE: _____

Signature (Patient)

(Signature of parent, guardian, or authorized representative, when required)

“If we could look into each other’s hearts, and understand the unique challenges each of us faces, I think we would treat each other much more gently, with more love, patience, tolerance and care” - Marvin J. Ashton