Lifesprk SHINE ON™

Authorization to Release Protected Health Information

Client Information

Name	Date of Birth	Phone	
Street	City	State	Zip

Directions for Release of Information

Recipient of Information: I authorize Lifesprk to release my health information to the following:

Organization: ____
Person:____
Address:____
__
Phone: ____ Fax: ____

Type of Release: ❍ Hard copies (paper) ❍ Compact Disc ❍ Review of record ❍ Discussion

Delivery Method: ❍ Mail ❍ Fax ❍ Pick up by Client or Client Representative (requires ID)

Information to be Released

Release my entire health record **OR** check below to specific parts of your health record:

❍ Nursing notes ❍ Medication records ❍ Discharge summary and/or instructions

❍ Physician orders ❍ Emergency or urgent care reports ❍ Billing records ❍ Service Plan

Other (describe):____.

Information in your records about mental health evaluation and treatment, drug or alcohol use, and HIV/AIDS will be released unless you complete this blank. Exclude: ____.

This authorization applies to health records created through the date I sign this form, unless I specify dates of service here. Optional: Release only records from _____/_____/________ to _____/_____/________.

Purpose for Releasing Information (you may check "at my request" if you do not wish to state another purpose):

❍ At my request ❍ Personal use or review ❍ Treatment/continuing care ❍ Long-term care insurance

❍ Insurance application ❍ Legal purposes ❍ Social security disability ❍ Payment

❍ Other: ____.

This is a legal document. Please read carefully. Your signature means you understand and accept the terms on this form.

This form expires 12 months from the date you sign it, unless you enter a different date or event here on the next line:
____.

I understand the following: (1) I may revoke this authorization at any time by sending a written statement to Lifesprk, Attention Privacy Officer, 5320 W. 23rd Street, #130, St. Louis Park MN 55416. If Lifesprk has already released health information based on this authorization, my revocation will not apply to those records. (2) This authorization is voluntary. Lifesprk will not condition treatment on whether I sign this form. (3) Once the information covered by this form is released, it may no longer be protected under the state or federal privacy regulations and the recipient might re-disclose the information. (4) I may have to pay Lifesprk a fee for releasing records. Any fees charged will comply with federal and state law. (5) If Lifesprk has received information from other organizations and filed it in the record Lifesprk maintains about you, that information may be released with your Lifesprk records.

Signature	Date Signed
Printed name of person signing (if not the Client):	Explanation of authority to sign (if not the client)