LifeStance HEALTH

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

Patient Name: _____

Patient DOB: _____

Provider: _____

INFORMATION TO BE EXCHANGED WITH:

I authorize LifeStance Health, Inc., and it's affiliate, (collectively "Provider") to share Protected Health Information ("PHI") about the Patient identified above with the following recipient:

Name: _____

Organization: _____

Address: _____

Suite Number: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Fax Number (optional): _____

I understand that "share" means to disclose orally in conversation, in writing or via electronic transmission. This authorization permits Provider to share information requested regarding my behavioral health treatment or the following types of information about the Patient (check all that apply):

☐ Evaluations
☐ Diagnosis
☐ Treatment Plan
☐ Mental Health Record Summary
☐ Medical/Hospital Records
☐ Psychological/Medical Test Results
☐ Discharge Summary
☐ Other: _____

☐ HIV/AIDS Diagnosis or Treatment Infection
☐ Sexually Transmitted Disease Diagnosis or Treatment Information
☐ Genetic Screening Test Results
☐ Substance Abuse Treatment or Diagnosis

The purpose for sharing this information: _____

I understand that only the individual who has consented for care (including minors as required or permitted by state law) can authorize the release of PHI. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can revoke this authorization at any time by sending a message via the patient portal or by writing:

LifeStance Health
4515 SE Milwaukie Ave
Portland, OR 97202-4940

If I cancel this authorization, I understand that cancellation will not apply to the extent that LifeStance has already relied upon my consent prior to receiving my written revocation. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled, including after any revocation of this authorization. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. Unless I revoke it earlier this authorization will expire one year after the date of my last visit with Provider or one year after the date I terminate my patient-provider relationship with LifeStance providers, whichever occurs later in time. Further, I understand that a copy of this document may be faxed or mailed to the above Recipient(s).

Date: _____

Signature: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable: _____