



LIFE MANAGEMENT ASSOCIATES, LLC

AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

REQUEST INFORMATION

RELEASE INFORMATION

For an Adult: I, _____, , DOB: ____ / ____ / ____
Client Name please print

For a Minor: I, _____, the parent/guardian of _____,
Parent/Legal Guardian Name please print Name of Minor (less than 18 years of age) please print

DOB: ____ / ____ / ____ a minor,

Hereby authorize and direct Life Management Associates, LLC to obtain from:

Name and/or Agency/Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Office: (____) _____ Fax: (____) _____

The following information:

- | | | |
|--|---|--|
| <input type="checkbox"/> Admission report/notes | <input type="checkbox"/> Prognosis and aftercare plan | <input type="checkbox"/> GAL, guardian ad litem report |
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological reports | <input type="checkbox"/> others, specify _____ |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Psychological testing results | _____ |
| <input type="checkbox"/> Educational records and reports | <input type="checkbox"/> Vocational testing results | _____ |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Discharge summary with diagnosis | _____ |
| <input type="checkbox"/> Treatment plan with progress | <input type="checkbox"/> Family systems information | _____ |
| <input type="checkbox"/> Psychiatric reports | <input type="checkbox"/> Child custody information | _____ |

The above information will be used for the following purposes:

- | | |
|--|--|
| <input type="checkbox"/> Planning appropriate treatment or program | <input type="checkbox"/> Family systems evaluation |
| <input type="checkbox"/> Continuing appropriate treatment or program | <input type="checkbox"/> Child custody evaluation |
| <input type="checkbox"/> Determining eligibility for benefits or program | <input type="checkbox"/> GAL, guardian ad litem report |
| <input type="checkbox"/> Case review | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Updating files | |

Furthermore, I hereby authorize Life Management Associates, LLC to disclose to name and/or agency/organization as Indicated above:

Name and/or Agency/Organization: _____ **As Indicated above**

Address: _____ **As Indicated Above** City: _____ **As Indicated Above** State: ___ as above _____ Zip: ___ as above ___

Office: (____) _____ **As Indicated above** Fax: (____) _____ **As Indicated above**

The following information: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. These regulations prohibit Life Management Associates, LLC or the above person, organization, or agency from making any further disclosure of this information without prior written consent.

I understand that I have no obligation whatsoever to disclose any information from my record, and I understand that I may revoke this consent at any time by notifying Life Management Associates, LLC or the above person, organization, or agency in writing and/or by specifying an event or condition upon which my consent will expire without revocation.

I have read or had this form read and explained to me and I understand its contents. I have completed the above to the best of my ability and fully understand the importance of this relationship. I give my consent and with my signature give permission to request and/or release this information. This authorization will automatically expire in 12 months from the date signed.

Your relationship to client: ___ Self, ___ Parent/legal guardian, ___ Legal representative, ___ Other (describe) _____
If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Client's Signature: _____ Date ____ / ____ / ____

Parent/guardians/personal representative (if applicable)

Signature: _____ Date ____ / ____ / ____

Representative of Life Management Associates, LLC

Signature: _____ Date ____ / ____ / ____