RELEASE OF INFORMATION
REQUEST FOR INFORMATION

www.lifestrategyconsultants.com
Phone: (717) 376-3075
Fax: (844) 252-3899

Client Name_____ Date of Birth____/____/____

Address_____

City_____ State_____ Zip_____

Phone (_____)_____

I consent to ❑ Release ❑ Request the following information for the purpose of:

❑ Continuity of Care ❑ Billing ❑ Other _____

❑ Admission
❑ Dates of Service/Attendance
❑ Diagnosis/Prognosis
❑ Evaluations/Assessments
❑ Intake Note
❑ Medical History & Physical
❑ Patient Data Form
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Social/Legal History
❑ Summary of Treatment
❑ Termination Note
❑ Treatment Plan(s)
❑ Other _____

Information may be released to/requested from:

RELEASE/REQUEST OF INFORMATION

Name/Organization_____

Address_____

City_____ State_____ Zip_____

Phone (_____)_____ Fax (_____)_____

Email _____

I understand that this information may be released in oral or written form.
(Clients age 14 or older must sign this form. For clients under age 14, a Parent/Guardian/POA must sign.)

Client Signature_____ Date _____

Signature of Witness_____ Date_____

The client ❑ accepted ❑ declined a copy of this form.

This information is being disclosed from health records that may be protected by law. I understand that I have the right to request to inspect materials that will be released. I understand that I may revoke this authorization at any time by notifying Life Strategy Consultants, LLC staff verbally or in writing.

For verbal revocation: Authorization was revoked on _____ at _____
am/pm
Life Strategy Consultants, LLC staff signature _____
Client/Parent/Guardian/POA signature (if available)
This authorization shall expire six (6) months after termination of treatment unless otherwise specified. If the client is not in treatment at the time of signing, this authorization will expire three (3) months after signing.