



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 _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Admission | <input type="checkbox"/> Medical History & Physical | <input type="checkbox"/> Summary of Treatment |
| <input type="checkbox"/> Dates of Service/Attendance | <input type="checkbox"/> Patient Data Form | <input type="checkbox"/> Termination Note |
| <input type="checkbox"/> Diagnosis/Prognosis | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan(s) |
| <input type="checkbox"/> Evaluations/Assessments | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Intake Note | <input type="checkbox"/> Social/Legal History | |

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For verbal revocation: Authorization was revoked on _____ at _____ am/pm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.