RELEASE OF INFORMATION
REQUEST FOR INFORMATION

MEDICAL PROVIDER

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 ❑ 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For verbal revocation: Authorization was revoked on ______________________at ____________am/pm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.

Revised April 2018