Life Style Consultant Services

Authorization of Disclosure for Release of Information of Treatment

Client Name: ________________________ DOB :_______________ Record # _______________

I, ____________________________________ , hereby authorize Life Style Consultant Services to share specified protected information with ____, I further authorize___________________________ to release specified protected mental/behavioral health information of me/my child's record with Life Style Consultant Services.

Purpose of the disclosure: □Assist with treatment □Referral □At Request of Client

□Other ______________________________

This information shall include only the following:

	Treatment Progress Summary		Diagnoses/Psychiatric Information
	Service Plan Documentation		Discharge Summary
	Progress Note Documentation		Verbal Communication
	Alcohol/Drug Treatment Information		Psychological Information
	Medical History and Physical		Other (Specify):

___ *Check here if information related to HIV infection, AIDS or AIDS related conditions maybe release*

Check here if minor client seeks release of information for treatment of venereal disease, pregnancy, abuse of controlled substances or alcohol, or emotional disturbances. (Client may authorize release)

My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality, I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred.

I understand that the above recipient party, without my further consent, may not release this information. Life Style Consultant Services is required by HIPAA privacy law to protect my health information. However once Life Style Consultant Services discloses information, I understand Life Style Consultant Services has no control over my privacy with regard to the recipient of the information.

This consent will automatically expire on: _________________________ (date, not to exceed one year) or 90 days after discharge from services, whichever comes first. I may request copy of this signed authorization. Life Style Consultant Services will provide treatment to me whether or not I sign this release.

I further understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. A legible photocopy of this document shall be considered as valid as the original.

Client Signature: ______________________________ Date: ______________________________

Guardian Signature:____________________________ Date:_______________________________

"Client must sign whether a child or adult; information protected by Federal Regulations 42 CFR Part II.