**LIFE MANAGEMENT FOR ADULTS, PLLC**

**PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

|  |  |
| --- | --- |
| Patient Name | Date of Birth    /   / |
| Address | |

**I authorize Life Management for Adults (“LMA”) to use or disclose the above-named individual's health information as described below.**

1. **This information may be disclosed to, and used by, the following individuals or organizations:**

|  |  |
| --- | --- |
| Name / Facility | Phone#       /      / |
| Address | Fax #       /      / |

**2. The type and amount of information to be used or disclosed is as follows (check off the appropriate item(s), and include other information where indicated):**

Initial Psychiatric Evaluation

Discharge Summaries

Psychological or psychiatric evaluation(s), reports, Assessments, treatment and/or psychotherapy notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records and behavioral observations or checklists completed by the patient, or similar documents.

Treatment, recovery, rehabilitation, aftercare plans and other similar plans.

Lab Reports

Billing records.

Drug and Alcohol history

HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here. Do not release these

Complete copy of the medical record.

Other

**This authorization may extend to the release of records related to** ALCOHOL ABUSE, DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC, AND/OR HIV DIAGNOSIS AND TREATMENT. The information obtained herein is confidential and must be used for the purpose it was requested any may not be re-released. The date of this authorization must not precede the date(s) of service that is requested.

**3. This information is being disclosed for the following purpose(s):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**4. Methods of disclosure authorized:** Faxed, written, phone conversation, in person and/or secure e-mail

**5. Patient Acknowledgments:**

* I understand that I have the right to revoke this authorization, at any time, by presenting written notification to LMA at the address above.
* I understand that the revocation will not apply to information that has already been released in reliance on this authorization.
* I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
* I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
* I understand that LMA generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party and I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
* Unless otherwise revoked, I understand that this authorization expires on the earlier of one year of the date this authorization is signed or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if left blank the authorization will expire one year from the date signed).

|  |  |
| --- | --- |
| **Electronic Signature of Patient or Legal Representative\*** |  |
|  | /   / |

*Please print your Full Name* Today’s Date

*If signed by legal representative, relationship to patient*

|  |  |
| --- | --- |
|  | /   / |

Signature of Witness Today’s Date

**Acceptance Checkbox\***  ***I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.***

***OR PRINT, SIGN AND RETURN***

P O Box 969, Portsmouth, NH 03802 | phone (603) 205-2953 / fax (888) 499-1213