**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***

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