LifeSmart Therapy Institute

AUTHORIZATION FOR RELEASE OF PROTECTED MENTAL HEALTH RECORDS AND INFORMATION

I give my permission to LifeSmart Therapy Institute and _____
to release the information contained in the record of: *Therapist Name*

PATIENT'S NAME:_____D.O.B:_____
TO:_____
_____
_____

I understand that such disclosure will be made for the purpose of confirming referral, historical background, evaluating and/or treatment, obtaining recommendations, following patient progress, casework planning and management or:

_____
Specific purpose of release if none of the above apply

I understand that, with few limited exceptions, LifeSmart Therapy Institute may not release this record unless I agree to the request. I understand that all information that I authorize for release will be held confidential and will not be released without my consent. I may withdraw my consent at anytime, except to the extent that the action has been taken in reliance hereon, otherwise, this consent will expire in six (6) months from the date of signature.

_____
Date

_____
Signature of patient OR

_____
Parent or Legal Guardian

I understand that the information provided in the psychological evaluation can be used against me in Court as it relates to the matter before the Department of Human Services.

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits.