LIFE MANAGEMENT ASSOCIATES, LLC

LMA

Authorization for Disclosure of Medical Information

☒ REQUEST CONFIDENTIAL MEDICAL INFORMATION

For an Adult: I, _____, , DOB: ____ / ____ / _____
Client Name *please print*

For a Minor: I, _____, the parent/guardian of _____,
Parent/Legal Guardian Name *please print* Name of Minor (less than 18 years of age) *please print*

DOB: ____ / ____ / _____ a minor,

Hereby authorize and direct Life Management Associates, LLC to obtain from:

Name and/or Agency/Organization: _____

Address: _____ City: _____ State: _____ Zip: _____

Office: (_____) _____ Fax: (_____) _____

The following information only: **Test Results for Novel Coronavirus (COVID-19)**

Delivery options: ☐ Mail (to address below), ☐ Fax (to number below), ☐ Hand Carry

The above information will be used for the following purposes:
___X___ Planning appropriate treatment or program ___X___ Continuing appropriate treatment or program

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. These regulations prohibit Life Management Associates, LLC or the above person, organization, or agency from making any further disclosure of this information without prior written consent.

I understand that I have no obligation whatsoever to disclose any information from my record, and I understand that I may revoke this consent at any time by notifying Life Management Associates, LLC or the above person, organization, or agency in writing and/or by specifying an event or condition upon which my consent will expire without revocation.

I have read or had this form read and explained to me and I understand its contents. I have completed the above to the best of my ability and fully understand the importance of this relationship. I give my consent and with my signature give permission to request and/or release this information. This authorization will automatically expire in 12 months from the date signed.

Your relationship to client: ☐ Self, ☐ Parent/legal guardian, ☐ Legal representative, ☐ Other _____
If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ____/ _____/ ____

Parent/guardians/personal representative, Signature: _____ Date ____/ _____/ ____

Signature: _____ Date ____/ _____/ ____

Representative of Life Management Associates, LLC

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