



LIFE MANAGEMENT ASSOCIATES, LLC

AUTHORIZATION TO REQUEST AND/OR RELEASE INFORMATION

☐ REQUEST INFORMATION

☐ RELEASE 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:

_____ Admission report/notes	_____ Prognosis and aftercare plan	_____ GAL, guardian ad litem report
_____ Academic testing results	_____ Psychological reports	_____ others, specify _____
_____ Progress reports	_____ Psychological testing results	
_____ Educational records and reports	_____ Vocational testing results	
_____ Medical reports	_____ Discharge summary with diagnosis	
_____ Treatment plan with progress	_____ Family systems information	
_____ Psychiatric reports	_____ Child custody information	

The above information will be used for the following purposes:

_____ Planning appropriate treatment or program	_____ Family systems evaluation
_____ Continuing appropriate treatment or program	_____ Child custody evaluation
_____ Determining eligibility for benefits or program	_____ GAL, guardian ad litem report
_____ Case review	_____ Other (specify) _____
_____ Updating files	

Furthermore, I hereby authorize Life Management Associates, LLC ☐ to disclose to name and/or agency/organization as indicated above:

Name and/or Agency/Organization: _____ **As Indicated above**

Address: _____ **As Indicated Above** City: _____ **As Indicated Above** State: ____ as above Zip: ____ as above

Office: (____) _____ **As Indicated above** Fax: (____) _____ **As Indicated above**

The following information: _____

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 (describe) _____
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: _____ Client's Signature: _____ Date ____/____/____

Parent/guardians/personal representative (if applicable), Signature: _____ Date ____/____/____

Representative of Life Management Associates, LLC

Signature: _____ Date ____/____/____