RELEASE OF INFORMATION

Full Name of Client:	
DOB:	Parent/Guardian Giving Consent:
Full Address:	
Client Telephone#:	Parent/Guardian Telephone#:

1. This consent cannot be in effect any longer than one year from my signature date. Please indicate by initials how you wish it to expire:
   A. I wish the consent to expire in one year ☐
   B. I wish the consent to expire on the indicated date, earlier to one ☐ year:_____

2. I authorize a release of records by any of the following methods as indicated by my initials:
   Verbally, Mail, Secure Fax, or Electronically ☐

3. I authorize unrestricted access to ALL types of records as needed. ☐ Yes ☐ No

   If unrestricted access is NOT authorized, indicate the type of information to be released by initialing.

   ☐ Billing
   ☐ Counseling Sessions
   ☐ Medications/Medical History
   ☐ Psychological Reports
   ☐ Scheduling
   ☐ Transfer/Discharge
   ☐ Treatment Plans
   ☐ Other (specify):

   FOR REVOCATION ONLY:

   *Confidential health and mental health treatment records will not be segregated unless requested.

   *Special charges may apply for records management requests.

4. Release of Information: (Please authorize and address separately all persons/agencies that apply)

   *By my initials, I request and authorize LifeWorks and/or my therapist to: Release to and Obtain from ☐

Person/Agency: _____

Address: _____

Telephone #: _____ Fax #: _____

For the Purpose of: Treatment Collaboration _____

This release is in accordance with the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. I understand and hold harmless LifeWorks Counseling & Consulting, Inc. as not liable in regard to the use of information that I have authorized for release or exchange. The State of Indiana (16-39-1-4) restricts consent to release information to the date I have stated. I understand that my consent is terminated when the purpose of the release is fulfilled. I may cancel my consent at anytime by notifying LifeWorks with a written statement requesting such action. To be maintained more than one year, this release must be renewed annually. However, my cancellation does not affect past action already taken with any such information that was released with my consent. I voluntarily authorize disclosure of this information. I understand that the information being released is for professional use only and may not be provided in whole or in part to any other agency or individual other than those stated above. Except as provided under Federal Law 45 CFR 164.524, this information has been released from records protected by Federal Law (45 CFR Part 2) and prohibits further disclosure and/or re-disclosure by the recipient of the information. A general release of your mental health records is not sufficient for this purpose. I understand that any disclosure of my mental health records comes with the potential that unauthorized re-disclosure by other parties or entities who may receive this information may not be protected by Federal Confidentiality rules. ☐

Signature (Client/Parent/Guardian):	Date:
Witness:	Date:

Last Name	First	Middle	Date	Client #