

Release of Information Authorization

Client Name: _____ **Date of Birth:** _____
(Print Full Name)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Soc. Sec. # : _____ **Phone:** _____

I hereby freely and voluntarily authorize Life Management Systems EAP to:

_____ **Release Information to:** _____

_____ **Receive Information from:** _____

_____ **Exchange Information with:** _____

The following information from my records (extent of specific information to be released is limited to)

- | | |
|--|---|
| <input type="checkbox"/> The fact that I have accepted referral to EAP | <input type="checkbox"/> Progress |
| <input type="checkbox"/> Dates of Service | <input type="checkbox"/> Compliance |
| <input type="checkbox"/> Assessment / Diagnosis | <input type="checkbox"/> Work-related Issue |
| <input type="checkbox"/> Recommendations | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Case Summary | Other: _____ |

The purpose or need for such information is:

- | | |
|---|---|
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Liaison for work |
| <input type="checkbox"/> Coordination of Care | Other: _____ |

I understand that I have the right to inspect the information to be released and I may withdraw this authorization at any time, except to the extent the action has been taken based on this authorization. I understand that this authorization shall expire, without my express revocation, 90 days from the date written below.

Client Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

This information is disclosed from records that are the property of Life Management Systems. Further disclosure without specific written consent of the person to whom it pertains is prohibited. A general authorization for the release of medical records or other information is not sufficient for this purpose. Federal Regulation (42 CFR, Part 2)