Life Development Resources, PA
Consent for Release of Information

This authorizes Life Development Resources, PA to use and disclose the specific health information described below concerning:

Client:_____ Date of Birth:_____

This will authorize _____, Life Development Resources Therapist to:

Please check all that apply: Release information to ____ and/or Obtain information from ____

Relationship to Client: ___Primary Care Physician ___Therapist ___School/Work ___Family ___ Other:_____

Name(s):_____ Organization/Clinic:_____

Address:_____ City _____State _____Zip _____

Phone:_____ Fax:_____

Timeline for records to be released: _____All ____Specific Dates:_____

The information to be disclosed is **(please check all info that you are willing to have exchanged):**

	History and intake information		Social/ Psychological/ Medical reports
	Consultation notes/ progress reports		Chemical dependency abuse or diagnosis, history and treatment (protected by Federal and State regulations 42 CFR Part 2 and ORS 430.399(5), 179.505)
	Treatment plan, goals, and results		Medications used in treatment
	Court or probation records		Other (specify)

The purpose of the information release is(please check all that apply):

	Diagnosis and evaluation		To facilitate treatment/coordination of care
	Treatment planning		Other (specify)

If I am requesting the Authorization from you for my use and disclosure or to allow another health care professional or entity to disclose information to me: (1) You have the right to inspect a copy of the protected information to be used or disclosed; (2) You may refuse to sign this authorization; and (3) I must provide you with a copy of the signed authorization at your request. You may revoke this consent at any time and that upon fulfillment of the above stated purposes(s) or within one year, this consent will automatically expire without express revocation.

By signing this authorization, you may be directing me to disclose your health information to a person or organization that does not have the same obligations to protect privacy required of health care practitioners under state and federal law. The disclosure of the information specified above may carry with it the potential for unauthorized disclosure of your protected health information and loss of protection under state and federal law.

You may request that I require the recipient of your protected health information to sign a Confidentiality Agreement in which the recipient agrees to limit its use and disclosure of your information as specified by the confidentiality agreement. If the intended recipient refuses to sign the confidentiality agreement you request, I will not release the information.

I have reviewed the Authorization and I understand it. I understand that the information used or disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.

_____ _____

Signature of Client Date

_____ _____

Signature of parent or guardian or witness Date