Print Form

Office use only: (enter address & numbers below)

Solutions For Life, Inc.

Counseling, Life Coaching, and Consulting

Helping you discover Solutions for your life one session at a time.

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

Patient Last Name	Initial	Patient First Name

Address	City	State	Zip Code	Phone number

☐ I authorize my therapist ☐ to release information regarding my therapy and test to the following individual(s):

Individual's Name _____ Relationship to Client _____

Individual's Name _____ Relationship to Client _____

Individual's Name _____ Relationship to Client _____

☐ I do not consent to release information regarding my therapy and test to the following individual(s):

Individual's Name _____ Relationship to Client _____

Individual's Name _____ Relationship to Client _____

Individual's Name _____ Relationship to Client _____

Please check all that apply below.

☐ I understand that, unless withdrawn, this authorization will expire ☐ from the date of signature. A photocopy of this form will be considered as valid as the original.

☐ I understand that I may revoke this authorization at any time by notifying my therapist listed above at Solutions For Life, Inc., in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

☐ I understand I may not hold my therapist listed above, nor Solutions For Life, Inc. for ramifications of the release of information I have authorized to the individual(s) I have listed above.

☐ I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment with my therapist list above at Solutions For Life, Inc.

☐ I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Client's Signature _____ Today's Date _____

Parent/Legal Guardian/Authorized Person _____ Relationship to Client _____ Today's Date _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Last Name	Initial	Patient First Name

Address	City	State	Zip Code	Phone number

☐ I authorize the following person or types of people to disclose my information.

Name of Provider _____ Relationship to Client _____

Address _____ City _____ State _____ Zip Code _____

Office number _____ Fax number _____

I authorize the following information to be used or disclosed on my behalf: (Please check all that apply)

☐ ***All my health information*** *(e.g. diagnosis, claims, provider) may be disclosed.*

☐ ***Only limited information listed below*** *may be disclosed.*

- ☐ Appeal
- ☐ Benefits & Coverage
- ☐ Biling
- ☐ Claims & Payment
- ☐ Diagnosis & Procedure
- ☐ Eligibility & Enrollment
- ☐ Financial
- ☐ Medical Records (excludes psychotherapy notes)
- ☐ Physician & Hospital
- ☐ Pre-certification & Pre-authorization
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Behavioral Health
- ☐ Other (please list below) _____

☐ ***I authorize the release of the following types of sensitive information*** *(check all blocks that apply)*

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/Substance Abuse
- ☐ Genetic Testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental Health
- ☐ Sexually Transmitted or Other Communicable Diseases
- ☐ Other (please list below) _____

Please check all that apply below.

☐ I understand that, unless withdrawn, this authorization will expire ☐ from the date of signature. A photocopy of this form will be considered as valid as the original.

☐ I understand that I may revoke this authorization at any time by notifying my therapist listed above at Solutions For Life, Inc., in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

☐ I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment with my therapist list above at Solutions For Life, Inc. except where disclosure of information is necessary for the treatment.

☐ I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Client's Signature _____ Today's Date _____

Parent/Legal Guardian/Authorized Person _____ Relationship to Client _____ Today's Date _____