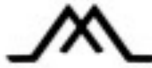

JD's Midlife Tools For Living Practices, LLC

Release of Information Authorization

I, ____ whose Date of Birth is ___________
[Client Name]
authorize **Midlife Tools For Living Practices, LLC** to disclose to and/or receive the following information from:
____.
[Name of Person or Title of Person or Organization]

<u>Description of Information to be Disclosed</u> (check each item to be disclosed)

___ Two Ways (Verbal and Written)	___ Complete Record
____ Presence/Participation in Treatment	___ Progress Notes
___ Assessment/Diagnosis	___ Discharge/Transfer Summary
___ Psychosocial Evaluation	___ Billing Records
____Treatment Plan/Summary	___ Other

<u>Purpose</u>
This information may be used or disclosed in connection with <u>mental health treatment, payment, or healthcare operations.</u>

If the purpose <u>is other than as specified above, please specify</u>:
____
____

<u>Revocation</u>
I understand that I have a right to revoke this authorization, in writing, at any time **<u>by sending written notification</u>** to Midlife Tools For Living Practices. LLC. I further understand that information shared during the time the authorization was in good standing will not be revoked.

<u>Expiration</u>
Unless sooner revoked, this authorization expires on the following date:_____________ or as otherwise indicated: ____

<u>Conditions</u>
I further understand that Midlife Tools For Living Practices, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: possible termination of treatment services under rare circumstances.

<u>Form of Disclosure</u>
Unless you have specifically requested in writing that the disclosure be made in a certain format,

we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections. I understand that Midlife Tools For Living Practices, LLC. does not redisclose information.

I will be given a copy of this authorization for my records.

____

Signature of Client Date

____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

___ Check here is client refuses to sign.

____

Signature of Witness