LifeSpire, LLC

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Authorization to Use and Disclose Protected Health Information (PHI)

CLIENT NAME: **DATE OF BIRTH:**

I hereby give consent and authorize LifeSpire, LLC to allow the use and sharing of Protected Health Information (PHI) about the above-mentioned person to:

Information to be used or disclosed may include: (check each desired)

- ☐ Referral/treatment summary/update of progress in treatment
- ☐ Social, family, educational, and vocational history
- ☐ Academic and educational records
- ☐ Admission/discharge summary
- ☐ Psychological evaluation
- ☐ Treatment plan
- ☐ Other- list specific items below:

This information will be used or disclosed for the following purposes:

- ☐ Inform referral source of follow-through in treatment
- ☐ Litigation/legal matter concerning client
- ☐ Facilitate continuity of care
- ☐ Other- list specific purpose below:

I understand and agree that this Authorization will be valid and in effect from the date of signature and will automatically expire one year after the date of signature. I understand that after that date, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer, Jamie Bolton, PsyD. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from LifeSpire, LLC, nor will it affect my eligibility for benefits.

I understand that I may inspect and have a copy of the information described in this authorization. There may be a cost for this copy or other services.

I have read this form or had it explained to me and I understand its contents.

*Discuss with your therapist prior to signing this form.

_____ _____
Client or Guardian Signature Date

I, a mental health professional have discussed the issues above with the client and/or guardian. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Clinician Signature/Credentials Date