



**Authorization for Use/Disclosure of Information for:** \_\_\_\_\_

I \_\_\_\_\_, hereby authorize staff at **Life & Work Solutions, Inc.** to:

\_\_\_\_\_ (Initials) Use the following protective health information, and/or

\_\_\_\_\_ (Initials) Disclose the following protective health information to:

**Name of Agency** \_\_\_\_\_

- |                                       |  |                                       |                                   |
|---------------------------------------|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Probation/DJJ | <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Relative |
| <input type="checkbox"/> GAL          | <input type="checkbox"/> Attorney      | <input type="checkbox"/> PCP          | <input type="checkbox"/> Other    |

Address/City/Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

This protective health information is being used or disclosed for the following purposes:

- |  |   |
|--|---|
| <input type="checkbox"/> Evaluation/Assessment Results | <input type="checkbox"/> Progress Updates   |
| <input type="checkbox"/> Treatment Recommendations     | <input type="checkbox"/> Discharge Planning |

Other: \_\_\_\_\_

This authorization shall be in force and effect until \_\_\_\_\_ at which time this authorization to use/disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Life & Work Solutions, Inc.** I understand that a revocation is not effective to the extent that **Life & Work Solutions, Inc.** has relied on the use or disclosure of the protective health information. I understand that information used or disclosed pursuant to this authorization may be subject to read disclosure by the recipient and may no longer be protected by federal or state law. Refusing to sign this will not condition my treatment, payments, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to:

- Inspect or copy the protective health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to **Life & Work Solutions, Inc.** from a third-party (if applicable).

\_\_\_\_\_  
Signature of Patient or Personal Representative Date

\_\_\_\_\_  
Therapist's Signature with Credentials Date