*Life Integration Therapies, Inc.*
*Kay E. Whitehead, MSW., LCSW., FT*
Psychotherapist
23 E. 39th Street
Indianapolis, In 46205

# AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the use of disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the person/entity authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Client Name: _____

Client Address: _____

Client City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____

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Personal Health Information to be Disclosed: Describe the personal information you are authorizing to be disclosed.

- ☐ Initial Evaluation
- ☐ Psychological Tests
- ☐ Treatment Plan
- ☐ Treatment Progress
- ☐ Clinical Notes
- ☐ Diagnosis
- ☐ Discharge Summary
- ☐ School Records
- ☐ Medical/Lab
- ☐ Verbal Exchanges
- ☐ Entire Record
- ☐ View Record Only
- ☐ Other: _____

_____

_____

_____

_____

_____

I understand that if all items above or entire record are checked, the requesting person may receive the complete contents of my record, and that Life Integration Therapies, Inc. cannot under a full release take responsibility for the disclosure of this information. It is assumed by Life Integration Therapies, Inc. that parties to whom information is released will be discrete in disclosing information.

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Person/Entity Authorized: Name the person or entity you are authorizing to give the information described above.

I hereby give my permission to Life Integration Therapies, Inc. to:

- ☐ Release to
- ☐ Exchange information
- ☐ Receive from

_____
(Name of Person or Entity)

_____
(Address)

_____
(City, State, Zip)

_____
(Telephone & Fax Numbers)

Purpose of the Disclosure: Note the reason the disclosure is being made.

- ☐ Diagnosis & Evaluation
- ☐ Personal Information
- ☐ Medication Management
- ☐ Treatment Assessment & Planning
- ☐ Psychiatric/ Psychological Evaluation & Assessment
- ☐ Compliance with Court-Ordered Evaluation
- ☐ Insurance/Billing
- ☐ Relocation/Exit Planning
- ☐ Other: _____

**Right to Revoke:** I understand that I may revoke this authorization at any time (except to the extent that action has already been taken based on this authorization) by written notification to Life Integration Therapies, HIPPA Privacy Officer, 23 E.39th St. Indianapolis In, 46205

**Expiration**: I understand this authorization will expire 180 days from the date written below according to the State of Indiana provisions, unless otherwise specified. Please specify date or event upon which this consent expires (if different from above):

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**SIGNATURE:**

I, _____, have had full opportunity to read and consider the contents of this authorization and I confirm the contents are consistent with my direction.

*Signature:*_____ *Date:* _____

*Witness:* _____ *Date:* _____

Mail to: Kay E. Whitehead MSW, LCSW 23 E. 39th St. Indianapolis, IN 46205

If a personal representative on behalf of this individual signs this authorization, complete the following:

*Printed Name of Personal Representative:* _____

*Relationship to Individual:* _____

**A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL.**
**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**

Please initial to indicate you received a copy: _____

NOTICE TO RECIPIENT OF INFORMATION

**This information has been disclosed to you from records the confidentiality of which may be protected by Federal and/or State Law. If the records are so protected, Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**

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PO Box 68723 Indianapolis, IN 46268
Specializing in Grief, Traumatic Loss, Women's Issues, Spirituality, 12-Step Recovery