LIFEWORKS/PSYCHIATRIC ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

Please note that adult patients have the option to register for a FollowMyHealth account and can view their records there immediately, rather than going through the records request process.

LifeWorks/Psychiatric Associates have partnered with Sharecare to fulfill your requests for records. If you would like LifeWorks/Psychiatric Associates to send records, please utilize our online submission portal by visiting https://www.lifeworksdm.com/resources/forms/request-medical-records/ or https://psychassociates.net/patient-resources/request-medical-records/.

PATIENT INFORMATION		
Patient Name		Date of Birth
Address		Phone Number
City	State	Zip Code

INITIAL ACTION
☐ Keep on File for Future Use ☐ Request records from Agency/Name Listed Below

I AUTHORIZE LIFEWORKS/PSYCHIATRIC ASSOCIATES TO	☐ RELEASE INFORMATION TO: ☐ RECEIVE INFORMATION FROM:
Agency/Name	Relationship to Patient
Phone Number	Fax Number
Address	City, State, Zip Code
Email	☐ **This is my primary care provider.**

INFORMATION TO BE RELEASED (CHECK APPROPRIATE BOX(ES)):	
Only release Mental Health/Medical records checked below: ☐ Standard Release (Recent Intake Assessment, Last 3 Progress Notes, and Most Recent Treatment Plan) ☐ Most Recent Intake Assessment ☐ Last 3 Progress Notes ☐ Most Recent Treatment Plan ☐ Psychological Testing Interpretive Report ☐ Other (Specify Type) _____	**Only release Substance Use Disorder (SUD) records checked below:** ☐ Comprehensive Assessment/Update ☐ Letter of Recommendation ☐ Verification of Attendance Letter ☐ Progress Notes/Treatment Plan ☐ Transition/Discharge Summary ☐ Information Exchange for Family Involvement, Collateral, or Emergency Contact ☐ Other (Specify Type) _____
☐ **Or Any and All Mental Health/Medical Records Dated From:** **_____ to _____**	☐ **Or Any and All SUD Records Dated From:** **_____ to _____**

PURPOSE OF RELEASE (CHECK APPROPRIATE BOX(ES)):

The purpose of this release is for coordination of care or:

☐ Personal Use/Review* ☐ Family Involvement ☐ Litigation/Legal*
☐ Social Security Appeal/Disability* ☐ Collateral ☐ Continuation of Care
☐ Insurance Payment/Claim* ☐ Emergency Contact Only ☐ Other* _____

**Fees may be charged in accordance with state and federal guidelines.*

METHOD OF COMMUNICATION (CHECK APPROPRIATE BOX(ES)):

Electronic Methods:

☐ Non-Secure Email (PDF) ☐ Secure Email (PDF)
☐ CD (Password-Protected PDF)

NOTE: Transmission of records via standard email is not a secure method of transmission. By choosing email, I understand that I risk my information being intercepted by an unauthorized individual.

Standard Methods:

☐ Phone/Email Conversation ☐ Pick Up
☐ Fax ☐ Mail

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. Substance Use Disorder (SUD) records may not be re-disclosed to investigate or prosecute a patient. c. My SUD records are protected under the federal regulations governing confidentiality and SUD patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 164. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. e. Disclosure is only allowed with my authorization, except in limited circumstance as described in LifeWorks/Psychiatric Associates Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. This authorization shall be in force and effect until 1 year from the date of execution at which time this authorization expires. Fees may be charged in accordance with state and federal guidelines.

Patient/Legal Guardian Signature: _____ Date: _____

Representative's Relationship to Patient (Parent, Guardian, etc.): _____
NOTE: If signed by someone other than the patient, we need written proof of authority.

If you are completing this release for a minor patient involved in Substance Use Disorder (SUD) treatment, the minor patient must also consent to the release of their protected health information by signing below.

Minor Patient Signature: _____ Date: _____

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.