Lifetime Insight, LLC
440 Regency Parkway Dr., Suite 136
Omaha, NE 68114
Office: 402-934-7404
Fax: 402-909-0196

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

I hereby request and authorize:

Lifetime Insight, LLC
440 Regency Parkway Dr., Suite 136
Omaha, NE 68114
Office: 402-934-7404; Fax: 402-909-0196

To release written or verbal information to stated below:

Medical and mental health evaluations and treatment records, including laboratory reports, EKG/EEG reports, imaging reports, discharge summaries and medication reconciliation, and Emergency Department records.

Substance use treatment, Human Immunodeficiency Virus (HIV, AIDS), and illegal abuse records.

Other:

For the purpose of: Coordination of care Attorney/legal matters Other:

To the following:

Name of Practice or Physician:	
Address, City, State, Zip Code:	
Phone, and or Fax number, if known:	

I understand that this form may be used to release information related to mental health treatment, including assessments and laboratory reports. Any release of substance abuse information must be pursuant to 42 CFR.

This statement of consent can be revoked at any time before disclosure of the information, and expires 12 months after it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations.

I understand Lifetime Insight, LLC will not condition evaluation or treatment on whether I sign this authorization.

OR

_____ _____
(Signature of Patient) (Signature of guardian or authorized rep)

_____ _____
(Date) (Relationship of above person to patient)