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:

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

to release written or verbal information for medical, psychological and mental health evaluations and treatment records, including laboratory reports, EKG/EEG reports, discharge summaries and medication reconciliation, and Emergency Department records for the purposes of coordination and mental health care to:

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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 representative)

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