lifeworks
PSYCHOTHERAPY CENTER

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simply aware, fully alive

(847) 568 1100

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Authorization to Release Information

Client Name _____ Date of Birth _____

I hereby authorize _____ of LifeWorks Psychotherapy center LLC,

To release the ☐ verbal and/or ☐ written information necessary for the following purpose:
(check one or both)

☐ for psychotherapeutic treatment and coordination of care.

☐ for other _____

to the following person(s) _____
(name(s) of persons authorized to receive information),

This release will expire on _____ (mm/dd/yyyy), upon the happening of the following event:

_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, the use/disclosure is to be made to conform to my directions, and that I may revoke this authorization at any time. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____
Signature of Client Date of Signature

_____ _____
Signature of Personal Representative (if not client) Relationship to Client