Better Life PARTNERS

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Betterlifepartners.com

AUTHORIZATION FOR RELEASE OF INFORMATION

42 CFR COMPLIANT RELEASE

Member Name:_____

Date of Birth:_____

Organization/Individual Name:_____

I Hereby Authorize Better Life Partners Inc to (see checked items below) with the Organization or Individual above:

- ☐ Release Information to
- ☐ Obtain Information from

Reason for Request:_____

The Following Information is Requested to be Shared:

- ☐ All Available Information

or

Only those items that are pertinent to this referral:

- ☐ Office Notes
- ☐ Intake Assessments
- ☐ Urine Drug Test Results
- ☐ Psych/Social/Emotional Evaluation
- ☐ Medications
- ☐ Treatment Plans
- ☐ Counselor Reports
- ☐ Summaries
- ☐ Discharge Summary

Date Range of Records Release:

- ☐ All ***or*** From:_____to_____

ACKNOWLEDGEMENTS:
Read and Initial all statements below

_____I understand that the release of information is subject to State and Federal laws.

_____I acknowledge my permission to release the above information to and/or from the individual or agency I have named which may include drug and alcohol abuse information.

_____I understand that I may revoke this authorization at any time by notifying Better Life Partners, in writing, except to the extent that: a) action has been taken in reliance on this authorization; or b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

_____I understand that I have a right to request and receive a Notice of Privacy Practices from Better Life Partners.

_____I understand that requested information may be provided in verbal, written or electronic format.

_____I understand that, unless otherwise specified, all releases are valid for the duration of your care with Better Life Partners.

Print:_____

Signature:_____

Date:_____