LIFESTAGES FAMILY NEUROHEALTH
COMPLETE COGNITIVE CARE

Release/Request Information

Name of patient: _____ Date of birth: _____

I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life.

I authorize Lifestages Family Neurohealth, LLC to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

- ❑ Admission/discharge information
- ❑ Scheduled appointments
- ❑ Compliance with treatment
- ❑ Treatment summary
- ❑ Medications
- ❑ Treatment plan
- ❑ Progress notes
- ❑ Discharge plans
- ❑ Psychological evaluation
- ❑ Other: _____

This information is to be disclosed to/received from the person named below, who have the indicated relationship to me/the patient:

_____
Name / Relationship

_____ _____
_____ Phone

_____ _____
Address Fax

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire :

❑ one year from this date,
❑ upon my discharge from treatment by this agency or by the person specified above, or
❑ under these circumstances: _____.

_____
Signature of client or parent/guardian Printed name Date