Release of Information Date: _____, 20___

Client Name: _____ **Date of Birth**: ____/____/_____

I hereby authorize:

Life Resources, LLC
7501 O Street Suite 100
Lincoln, NE 68510
Phone: (402) 477-0651
Fax (402) 477-0332

◯ **To Provide** Protected Health Information to: ◯ **To Receive** Protected Health Information from:

Name: _____ Title: _____

Address: _____ City:_____ State:_____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

Information to be provided:

□ Progress Notes □ Psychiatric/Psychological Evaluation □ Verbal Communications □ Attendance Record □ Entire Record

Reason for Disclosure:

_____

_____

_____

_____

Communication between each party must have an expiration date. The validity of this release will extend for a period of one year from the signature date. I understand that this authorization shall be in effect until _____, 20____.

Clients may revoke an authorization to release information at any time by sending written notification.
I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ Date: ____/____/_____
Client Signature/Parent (if Minor)/Guardian

_____
Printed Name