# CONSENT TO OBTAIN RELEASE INFORMATION

TO: Name:_____ RE: Name:_____
Address:_____ Address:_____
Phone:_____ Phone:_____

I, _____, hereby request/authorize _____, from UPMC *Life*Solutions, to obtain/release the following information for the period of _____ to _____.

**The purpose of such disclosure is**:
____ To provide continuity of care when a referral is made.

____ To coordinate my return-to-work.

____ **Supervisory Referral –** I was referred to *LIfe*Solutions by my employer. To comply with my employer's policies, I authorize *Life*Solutions to tell my employer: a) if I have kept my appointments, b) if I am compliant with any course of treatment recommended by *Life*Solutions, and c) if treatment will require time off from work. I understand that my employer will not be given clinical information about me.

____ Other

**Information to be obtained/released**:
_____ Interview Information
_____ Drug/Alcohol History
_____ Diagnostic Impressions
_____ Progress Notes
_____ Treatment Summary
_____ Referral Recommendation
_____ Attendance
_____ Compliance with Treatment Recommendations
_____ Recommendations/feedback to be given to supervisor. (Describe and give purpose below).
_____
_____

____ Other (Describe the information to be obtained/released, to whom it will be released, and for what purpose)

I understand that by law I need not consent to the release of this information; however, I choose to do so willingly and voluntarily for the purpose specified above. I understand that once this information is disclosed according to the instructions above, if the information is released to a party not subject to HIPAA or state privacy regulations, the information may be subject to redisclosure by the recipient. I am aware that I may revoke this consent at any time if action has not already been taken. I understand that this consent lapses one hundred and eighty (180) days from the date of signature.

_____ _____
Client's Date of Birth Client's Signature Date

_____ _____
Client's Social Security Number Witness Date

____ Verbal Release given. (Client physically unable to give written consent).
Verbal consent requires two (2) witness signatures.

I witness that the client is definitely unable to provide a signature, but understands the nature of the release and freely gives his/her verbal consent.

_____ _____
Witness Date Witness Date

Please send information to: UPMC *Life*Solutions
112 Washington Place Suite 400
Chatham Center Two
Pittsburgh, PA 15219
Fax: 412-647-9484

LifeSolutions