Life's Energy
Wellness Center, Inc.

Client Name (Printed): _____ DOB:_____

I,_____Client/Parent/Guardian of Client Name) grant permission/

authorization for (releasing agency)_____ to release protected health

information to: **Life's Energy Wellness Center Inc. (LEWC Inc.).**

The Release of Information is for the purpose of: Assessment, Treatment Planning, Treatment,

Medical Records, Medical Information,Care Coordination, Medication Information, Lab Results,

Insurance Information, Referral.

Other (if applicable please specify:_____

The above named Agency/Provider will Maintain strict confidentiality of this information.

I understand that this authorization to release information is granted for one year expiring on:_____and may be rescinded/revoked upon receipt of my verbal, written, or taped request. I understand that I can end this authorization (permission to disclose information) at any time.
I understand that if I make a request to end this authorization, it will not include information that has already been used or disclosed on my previous permission. In any event the recipient should not re-disclose such information without my further written authorization unless otherwise provided by state or federal law. I understand that if my record contains information relating to chronic illness, substance use disorders, communicable diseases including HIV, AIDS or related illness, psychological or psychiatric conditions, or genetic testing this disclosure will include that information unless I specifically exclude such information from disclosure.I understand these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of the records from making and further disclosures to third parties without written consent of myself the client. I understand I will not be required to sign this form as a condition of services provided and may refuse to sign this Authorization. I understand that if service is requested by a non-treatment provider (e.g., Insurance company for the sole purpose of creating health information (e.g., physical exam), that service may be denied if authorization is not given. If treatment is research related, treatment may be denied if authorization is not given. I understand I have a right to this signed authorization that I may keep for my records. By signing I acknowledge that I have read, understand and accept the terms and policies of the releasing agency.

_____ _____
Client Signature Date

_____ _____
Legal Guardian/Representative Date

_____ _____
Witness Signature Date