L.I.F.E.
Lifting Individual & Family Expectations, Inc.
...supporting individuals and empowering families

Consent to Release Confidential Information

I, _____, ***please circle one*** (client, parent, guardian), born _____, do hereby consent and authorize:

Name of Agency/Person:	Lifting Individual and Family Expectations, Inc.
Address of Agency/Person:	1155 S. Semoran Blvd. Suite 1150 Winter Park, Fl. 32792
Phone Number of Agency/Person:	(321) 296-9383

to release specific information (pertaining to minor child name: _____,born _____), as outlined below to the agencies/persons indicated below:

Name of Agency:	
Address of Agency:	
Phone Number of Agency/Person:	

Specific information to be released is:

- ☐ Psychiatric, Drug Alcohol Records or Information
- ☐ Medical Records or Information to include but not limited to diagnosis, medication and dosage, medical conditions, lab results
- ☐ Social History
- ☐ Psychological Records or Information
- ☐ Educational Records or School Records
- ☐ Mental Health Records to include but not limited to diagnosis, assessments, treatment/service plan
- ☐ Significant Events
- ☐ Other: _____

I understand that I may revoke this consent at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on my consent. A photocopy of this authorization is to be considered as valid as the original document. The duration of this authorization is 12 months from the date of signature.

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature (if client under 18) Date

_____
Provider Name

_____ _____
Provider Signature Date