## Release of Records Exchange Form (Primary Care Physician)

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

By my signature below, I authorize LIFE Incorporated to release; or, obtain personal health care information to/from

Provider Name:		
Address:	_	
Telephone:		
Facsimile:		
and have access to; or, release the following records for	(DOB:	) as requested:
<ul> <li>Current Medical information and records</li> <li>Physician's Referral/Prescription for DT Services</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>☐ Current History and Physical</li> <li>☐ Physician's Medical Care Evaluation</li> <li>☐ Individual Program Plan or Indiv</li> <li>☐ SIB-R Results</li> <li>☐ PT/OT/Speech Assessment/Evaluation</li> </ul>	idual Support Plan
Other:		
We will use the medical records containing your personal health info	ormation to: <u>To develop and/or mainta</u>	ain services and supports
for the individual and maintain current, accurate records.		
This authorization will have an expiration date of one (1) calendar years	ear from the authorized signature below	Ι.
This authorization can be revoked at any time by delivering a revoca that the revocation will be effective except to the extent information a uthorization.		
LIFE, Inc. may only use or disclose your personal health information to protect your personally identifiable health information as describe this document says and authorize release of my personal health info copy of this Authorization for my records.	d in the attached Informed Consent Fo	rm. I understand what

Participant Signature (if applicable)

Date

Print Name

Signature of Legally Authorized Representative

Signature of LIFE Representative

Date

#### **Release of Records Exchange Form (Specialist)**

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

By my signature below, I authorize **LIFE Incorporated** to *release*; or, *obtain* personal health care information to/from

Provider Name:	-
Address:	-
Telephone:	-
Facsimile:	-
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Current Medical information and records</li> <li>Physician's Referral/Prescription for DT Services</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>Current History and Physical</li> <li>Physician's Medical Care Evaluation for DD Services</li> <li>Individual Program Plan or Individual Support Plan</li> <li>SIB-R Results</li> <li>PT/OT/Speech Assessment/Evaluation</li> </ul>
Other:	
We will use the medical records containing your personal health inform	ation to: <u>To develop and/or maintain services and supports</u>
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) calendar year	from the authorized signature below.
This authorization can be revoked at any time by delivering a revocatio that the revocation will be effective except to the extent information has authorization.	
LIFE, Inc. may only use or disclose your personal health information fo to protect your personally identifiable health information as described ir I understand what this document says and authorize release of my per- be given a signed copy of this Authorization for my records.	the attached Informed Consent Form.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date

Signature of LIFE Representative

## **Release of Records Exchange Form (School)**

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL INFORMATION

By my signature below, I authorize LIFE Incorporated to release; or, obtain personal information to/from

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for	r(DOB:) as requested:
<ul> <li>Individual Education Plan (IEP)</li> <li>SIB-R</li> <li>Physical Therapy Assessment/Progress Notations</li> <li>Speech Therapy Assessment/Progress Notations</li> <li>Medical Records</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>School Related Records</li> <li>Psychological Evaluation</li> <li>Occupational Therapy Assessment/Progress Notations</li> <li>Vocational Assessment/Progress Notations</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>Individual Program Plan or Individual Support Plan</li> </ul>
Other:	
We will use the records containing your personal information	ation to: To develop and/or maintain services and supports
for the individual and maintain current, accurate records	<u>.</u>
This authorization will have an expiration date of one (1)	) calendar year from the authorized signature below.
	ring a revocation in writing to the medical care provider named above and information has already been exchanged in reliance on my previous
LIFE, Inc. may only use or disclose your personal health to protect your personally identifiable health information	n information for purposes as required by law or regulations and will continue as described in the attached Informed Consent Form.
I understand what this document says and authorize rele be given a signed copy of this Authorization for my recor	ease of my personal health information as stated above. I understand I will rds.
Participant Signature (if applicable)	Date
Print Name	

Signature of Legally Authorized Representative

Date

Signature of LIFE Representative

# Release of Records Exchange Form (Service Coordination Agency)

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL INFORMATION

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Individual Education Plan (IEP)</li> <li>SIB-R or other Functional Assessment</li> <li>Physical Therapy Assessment/Progress Notations</li> <li>Speech Therapy Assessment/Progress Notations</li> <li>Medical Records</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>DD Assessment Summary</li> <li>Individual Support Plan (ISP)</li> </ul>	<ul> <li>School Related Records</li> <li>Psychological Evaluation</li> <li>Occupational Therapy Assessment/Progress Notations</li> <li>Vocational Assessment/Progress Notations</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>Individual Program Plan or Individual Support Plan</li> <li>Current History and Physical</li> <li>Service Coordination Plans</li> </ul>
Other:	
We will use the records containing your personal information	on to: To develop and/or maintain services and supports
for the individual and maintain current, accurate records.	
	g a revocation in writing to the medical care provider named above and
that the revocation will be effective except to the extent info authorization.	ormation has already been exchanged in reliance on my previous
LIFE, Inc. may only use or disclose your personal health in to protect your personally identifiable health information as	nformation for purposes as required by law or regulations and will continue s described in the attached Informed Consent Form.
I understand what this document says and authorize release be given a signed copy of this Authorization for my records	se of my personal health information as stated above. I understand I will s.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date
Signature of LIFE Representative	Date

# Release of Records Exchange Form (Developmental Disability Agency)

## AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL INFORMATION

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Individual Education Plan (IEP)</li> <li>SIB-R or other Functional Assessment</li> <li>Physical Therapy Assessment/Progress Notations</li> <li>Speech Therapy Assessment/Progress Notations</li> <li>Medical Records</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>DD Assessment Summary</li> <li>Individual Support Plan (ISP)</li> </ul>	<ul> <li>School Related Records</li> <li>Psychological Evaluation</li> <li>Occupational Therapy Assessment/Progress Notations</li> <li>Vocational Assessment/Progress Notations</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>Individual Program Plan or Individual Support Plan</li> <li>Current History and Physical</li> <li>Service Coordination Plans</li> </ul>
Other:	
We will use the records containing your personal information	n to: To develop and/or maintain services and supports
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) cale	endar year from the authorized signature below.
	a revocation in writing to the medical care provider named above and mation has already been exchanged in reliance on my previous
LIFE, Inc. may only use or disclose your personal health info to protect your personally identifiable health information as c	ormation for purposes as required by law or regulations and will continue described in the attached Informed Consent Form.
I understand what this document says and authorize release be given a signed copy of this Authorization for my records.	e of my personal health information as stated above. I understand I will
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date
Signature of LIFE Representative	Date

## Release of Records Exchange Form (Department of Health and Welfare)

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL INFORMATION

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for _	(DOB:) as requested:
<ul> <li>Individual Education Plan (IEP)</li> <li>SIB-R or other Functional Assessment</li> <li>Physical Therapy Assessment/Progress Notations</li> <li>Speech Therapy Assessment/Progress Notations</li> <li>Medical Records</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>DD Assessment Summary</li> <li>Individual Support Plan (ISP)</li> </ul>	<ul> <li>School Related Records</li> <li>Psychological Evaluation</li> <li>Occupational Therapy Assessment/Progress Notations</li> <li>Vocational Assessment/Progress Notations</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>Individual Program Plan or Individual Support Plan</li> <li>Current History and Physical</li> <li>Service Coordination Plans</li> </ul>
Other:	
We will use the records containing your personal informat for the individual and maintain current, accurate records.	tion to: <u>To develop and/or maintain services and supports</u>
This authorization will have an expiration date of one (1) of	calendar year from the authorized signature below.
	ng a revocation in writing to the medical care provider named above and formation has already been exchanged in reliance on my previous
LIFE, Inc. may only use or disclose your personal health i to protect your personally identifiable health information a	information for purposes as required by law or regulations and will continue is described in the attached Informed Consent Form.
I understand what this document says and authorize release given a signed copy of this Authorization for my record	ase of my personal health information as stated above. I understand I will Is.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date
Signature of LIFE Representative	Date

# Release of Records Exchange Form (Vocational Service Provider)

## AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL INFORMATION

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Individual Education Plan (IEP)</li> <li>SIB-R or other Functional Assessment</li> <li>Physical Therapy Assessment/Progress Notations</li> <li>Speech Therapy Assessment/Progress Notations</li> <li>Medical Records</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>DD Assessment Summary</li> <li>Individual Support Plan (ISP)</li> </ul>	<ul> <li>School Related Records</li> <li>Psychological Evaluation</li> <li>Occupational Therapy Assessment/Progress Notations</li> <li>Vocational Assessment/Progress Notations</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>Individual Program Plan or Individual Support Plan</li> <li>Current History and Physical</li> <li>Service Coordination Plans</li> </ul>
Other:	
We will use the records containing your personal information	on to: To develop and/or maintain services and supports
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) ca	alendar year from the authorized signature below.
	g a revocation in writing to the medical care provider named above and ormation has already been exchanged in reliance on my previous
LIFE, Inc. may only use or disclose your personal health in to protect your personally identifiable health information as	formation for purposes as required by law or regulations and will continue described in the attached Informed Consent Form.
I understand what this document says and authorize release be given a signed copy of this Authorization for my records	se of my personal health information as stated above. I understand I will s.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date
Signature of LIFE Representative	Date

## Release of Records Exchange Form (Certified Family Home Provider)

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

By my signature below, I authorize LIFE Incorporated to release; or, obtain personal health care information to/from

Provider Name:	-
Address:	-
Telephone:	-
Facsimile:	-
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Current Medical information and records</li> <li>Physician's Referral/Prescription for DT Services</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>Current History and Physical</li> <li>Physician's Medical Care Evaluation for DD Services</li> <li>Individual Program Plan or Individual Support Plan</li> <li>SIB-R Results</li> <li>PT/OT/Speech Assessment/Evaluation</li> </ul>
Other:	
We will use the medical records containing your personal health inform	nation to: <u>To develop and/or maintain services and supports</u>
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) calendar year	from the authorized signature below.
This authorization can be revoked at any time by delivering a revocation that the revocation will be effective except to the extent information has authorization.	
LIFE, Inc. may only use or disclose your personal health information for to protect your personally identifiable health information as described in I understand what this document says and authorize release of my per be given a signed copy of this Authorization for my records.	n the attached Informed Consent Form.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date

Signature of LIFE Representative

## **Release of Records Exchange Form (Other)**

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

By my signature below, I authorize LIFE Incorporated to release; or, obtain personal health care information to/from

Provider Name:	
Address:	
Telephone:	
Facsimile:	
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Current Medical information and records</li> <li>Physician's Referral/Prescription for DT Services</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>Current History and Physical</li> <li>Physician's Medical Care Evaluation for DD Services</li> <li>Individual Program Plan or Individual Support Plan</li> <li>SIB-R Results</li> <li>PT/OT/Speech Assessment/Evaluation</li> </ul>
Other:	
We will use the medical records containing your personal health inform	ation to: <u>To develop and/or maintain services and supports</u>
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) calendar year	from the authorized signature below.
This authorization can be revoked at any time by delivering a revocation that the revocation will be effective except to the extent information has authorization.	
LIFE, Inc. may only use or disclose your personal health information for to protect your personally identifiable health information as described in I understand what this document says and authorize release of my pers be given a signed copy of this Authorization for my records.	the attached Informed Consent Form.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date

Signature of LIFE Representative

## **Release of Records Exchange Form (Other)**

# AUTHORIZATION FORM FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

By my signature below, I authorize LIFE Incorporated to release; or, obtain personal health care information to/from

Provider Name:	
Address:	
Telephone:	-
Facsimile:	-
and have access to; or, release the following records for	(DOB:) as requested:
<ul> <li>Current Medical information and records</li> <li>Physician's Referral/Prescription for DT Services</li> <li>Developmental Therapy Assessment/Evaluation</li> <li>Medical-Social History Evaluation or Medical Social History</li> <li>DD Assessment Summary</li> </ul>	<ul> <li>Current History and Physical</li> <li>Physician's Medical Care Evaluation for DD Services</li> <li>Individual Program Plan or Individual Support Plan</li> <li>SIB-R Results</li> <li>PT/OT/Speech Assessment/Evaluation</li> </ul>
Other:	
We will use the medical records containing your personal health inform	ation to: <u>To develop and/or maintain services and supports</u>
for the individual and maintain current, accurate records.	
This authorization will have an expiration date of one (1) calendar year	from the authorized signature below.
This authorization can be revoked at any time by delivering a revocatio that the revocation will be effective except to the extent information has authorization.	
LIFE, Inc. may only use or disclose your personal health information for to protect your personally identifiable health information as described in I understand what this document says and authorize release of my per- be given a signed copy of this Authorization for my records.	the attached Informed Consent Form.
Participant Signature (if applicable)	Date
Print Name	
Signature of Legally Authorized Representative	Date

Signature of LIFE Representative