LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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:

☒ Current Medical information and records
☒ Physician's Referral/Prescription for DT Services
☒ Developmental Therapy Assessment/Evaluation
☒ Medical-Social History Evaluation or Medical Social History
☒ DD Assessment Summary
☒ Current History and Physical
☒ Physician's Medical Care Evaluation for DD Services
☒ Individual Program Plan or Individual Support Plan
☒ SIB-R Results
☒ PT/OT/Speech Assessment/Evaluation

☐ Other: _____

We will use the medical records containing your personal health information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form. I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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:

☒ Current Medical information and records
☒ Physician's Referral/Prescription for DT Services
☒ Developmental Therapy Assessment/Evaluation
☒ Medical-Social History Evaluation or Medical Social History
☒ DD Assessment Summary
☒ Current History and Physical
☒ Physician's Medical Care Evaluation for DD Services
☒ Individual Program Plan or Individual Support Plan
☒ SIB-R Results
☒ PT/OT/Speech Assessment/Evaluation

☐ Other:_____

We will use the medical records containing your personal health information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.
I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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 _____ (DOB: _____) as requested:

☒ Individual Education Plan (IEP)
☒ SIB-R
☒ Physical Therapy Assessment/Progress Notations
☒ Speech Therapy Assessment/Progress Notations
☒ Medical Records
☒ Developmental Therapy Assessment/Evaluation
☒ DD Assessment Summary
☒ School Related Records
☒ Psychological Evaluation
☒ Occupational Therapy Assessment/Progress Notations
☒ Vocational Assessment/Progress Notations
☒ Medical-Social History Evaluation or Medical Social History
☒ Individual Program Plan or Individual Support Plan

☐ Other:_____

We will use the records containing your personal information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.

I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

Release of Records Exchange Form (Service Coordination Agency)

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 _____ (DOB: _____) as requested:

- ☒ Individual Education Plan (IEP)
- ☒ SIB-R or other Functional Assessment
- ☒ Physical Therapy Assessment/Progress Notations
- ☒ Speech Therapy Assessment/Progress Notations
- ☒ Medical Records
- ☒ Developmental Therapy Assessment/Evaluation
- ☒ DD Assessment Summary
- ☒ Individual Support Plan (ISP)
- ☒ School Related Records
- ☒ Psychological Evaluation
- ☒ Occupational Therapy Assessment/Progress Notations
- ☒ Vocational Assessment/Progress Notations
- ☒ Medical-Social History Evaluation or Medical Social History
- ☒ Individual Program Plan or Individual Support Plan
- ☒ Current History and Physical
- ☒ Service Coordination Plans

☐ Other: _____

We will use the records containing your personal information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.

I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

Release of Records Exchange Form (Developmental Disability Agency)

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 _____ (DOB: _____) as requested:

☒ Individual Education Plan (IEP)
☒ SIB-R or other Functional Assessment
☒ Physical Therapy Assessment/Progress Notations
☒ Speech Therapy Assessment/Progress Notations
☒ Medical Records
☒ Developmental Therapy Assessment/Evaluation
☒ DD Assessment Summary
☒ Individual Support Plan (ISP)
☒ School Related Records
☒ Psychological Evaluation
☒ Occupational Therapy Assessment/Progress Notations
☒ Vocational Assessment/Progress Notations
☒ Medical-Social History Evaluation or Medical Social History
☒ Individual Program Plan or Individual Support Plan
☒ Current History and Physical
☒ Service Coordination Plans

☐ Other:_____

We will use the records containing your personal information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.

I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
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(T): 208.888.0076; (F) 208.888.1335

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

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 _____ (DOB: _____) as requested:

- ☒ Individual Education Plan (IEP)
- ☒ SIB-R or other Functional Assessment
- ☒ Physical Therapy Assessment/Progress Notations
- ☒ Speech Therapy Assessment/Progress Notations
- ☒ Medical Records
- ☒ Developmental Therapy Assessment/Evaluation
- ☒ DD Assessment Summary
- ☒ Individual Support Plan (ISP)
- ☒ School Related Records
- ☒ Psychological Evaluation
- ☒ Occupational Therapy Assessment/Progress Notations
- ☒ Vocational Assessment/Progress Notations
- ☒ Medical-Social History Evaluation or Medical Social History
- ☒ Individual Program Plan or Individual Support Plan
- ☒ Current History and Physical
- ☒ Service Coordination Plans

☐ Other: _____

We will use the records containing your personal information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.

I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

Release of Records Exchange Form (Vocational Service Provider)

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 _____ (DOB: _____) as requested:

☒ Individual Education Plan (IEP)
☒ SIB-R or other Functional Assessment
☒ Physical Therapy Assessment/Progress Notations
☒ Speech Therapy Assessment/Progress Notations
☒ Medical Records
☒ Developmental Therapy Assessment/Evaluation
☒ DD Assessment Summary
☒ Individual Support Plan (ISP)
☒ School Related Records
☒ Psychological Evaluation
☒ Occupational Therapy Assessment/Progress Notations
☒ Vocational Assessment/Progress Notations
☒ Medical-Social History Evaluation or Medical Social History
☒ Individual Program Plan or Individual Support Plan
☒ Current History and Physical
☒ Service Coordination Plans

☐ Other:_____

We will use the records containing your personal information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.

I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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:

☒ Current Medical information and records
☒ Physician's Referral/Prescription for DT Services
☒ Developmental Therapy Assessment/Evaluation
☒ Medical-Social History Evaluation or Medical Social History
☒ DD Assessment Summary
☒ Current History and Physical
☒ Physician's Medical Care Evaluation for DD Services
☒ Individual Program Plan or Individual Support Plan
☒ SIB-R Results
☒ PT/OT/Speech Assessment/Evaluation

☐ Other:_____

We will use the medical records containing your personal health information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

LIFE, Inc. may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the attached Informed Consent Form.
I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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:

☒ Current Medical information and records
☒ Physician's Referral/Prescription for DT Services
☒ Developmental Therapy Assessment/Evaluation
☒ Medical-Social History Evaluation or Medical Social History
☒ DD Assessment Summary
☒ Current History and Physical
☒ Physician's Medical Care Evaluation for DD Services
☒ Individual Program Plan or Individual Support Plan
☒ SIB-R Results
☒ PT/OT/Speech Assessment/Evaluation

☐ Other: _____

We will use the medical records containing your personal health information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

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I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date

LIFE Incorporated
545 N. Benjamin, Suite 155 – Boise, Idaho 83704
(T): 208.888.0076; (F) 208.888.1335

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:

☒ Current Medical information and records
☒ Physician's Referral/Prescription for DT Services
☒ Developmental Therapy Assessment/Evaluation
☒ Medical-Social History Evaluation or Medical Social History
☒ DD Assessment Summary
☒ Current History and Physical
☒ Physician's Medical Care Evaluation for DD Services
☒ Individual Program Plan or Individual Support Plan
☒ SIB-R Results
☒ PT/OT/Speech Assessment/Evaluation

☐ Other:_____

We will use the medical records containing your personal health information 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) calendar year from the authorized signature below.

This authorization can be revoked at any time by delivering a revocation in writing to the medical care provider named above and that the revocation will be effective except to the extent information has already been exchanged in reliance on my previous authorization.

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I understand what this document says and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records.

_____ _____
Participant Signature (if applicable) Date

_____
Print Name

_____ _____
Signature of Legally Authorized Representative Date

_____ _____
Signature of LIFE Representative Date