

Best Life Mental Health services, LLC

Release of Information

*** I authorize the sending and receiving of information between BLMHS and the following providers:**

*** For which of the following do you authorize the transfer of information?**

- Mental health records
- Communicable diseases (including HIV/AIDS)
- Alcohol/drug abuse treatment
- Other (describe)

This information may be used by the recipient for treatment, consultation, billing, claims, payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

*** For how long should this authorization be in effect?**

- Indefinitely
- Until treatment is completed
- Other (describe)

*** Signature (required)**

