



Consent to Obtain Release Information

To: Name: _____ Re: Name: _____
Address: _____ Address: _____
Phone: _____ Phone: _____

I, _____, hereby request/authorize _____ from _____

UPMC LifeSolutions to obtain/release the following information for the period of _____ to _____.

The purpose of such disclosure is:

- To provide continuity of care when a referral is made.
To coordinate my return to work.
Supervisory Referral: I was referred to LifeSolutions by my employer. To comply with my employer's policies, I authorize LifeSolutions to tell my employer: a) if I have kept my appointments, b) if I am compliant with any course of treatment recommended by LifeSolutions, and c) if treatment will require time off from work. I understand that my employer will not be given clinical information about me.
Other: _____

Information to be obtained/released

- Interview Information
Drug/Alcohol History
Diagnostic Impressions
Progress Notes
Treatment Summary
Referral Recommendation
Attendance
Compliance with Treatment Recommendations
Recommendations/feedback to be given to supervisor. (Describe and give purpose below.)

I understand that by law I need not consent to the release of this information; however, I do so willingly and voluntarily for the purpose specified above. I understand that this information is to be held strictly confidential and cannot be released again without my consent. I am aware that I may revoke this consent at any time if action has not already been taken. I understand that this consent lapses one hundred and eighty (180) days from the date of signature.

Client's Date of Birth _____ Client's Signature _____ Date _____
Client's Social Security Number _____ Witness _____ Date _____

- Verbal release given (client is physically unable to give written consent). Verbal consent requires signatures of two (2) witnesses.

I witness that the client is definitely unable to provide a signature but he/she understands the nature of the release and freely gives his/her verbal consent.

Witness _____ Date _____
Witness _____ Date _____

Please send information to:
UPMC LifeSolutions
University Center
2nd Floor, Suite 200
120 Lytton Avenue
Pittsburgh, PA 15213
Fax: 412.647.0333