Intake Form

Date: ________________

First Name:___________________________________M. I: _______Last Name: ____________________________________

Date of Birth:_______________Age:__________SSN#____________________________________Gender: ☐ Male ☐ Female

Current Address:____Apt. #: _________________

City:___________________State:_________Zip:___________County:_________________Referral Source: _______________

Indicate the best way to reach you: ☐Home #______________________________________☐Cell #___

_______________________Text OK? ☐Yes ☐ No Do you have difficulty with reading or writing? ☐ Yes ☐ No Name of person com pleting form: ______________________________ **In case of emergency, who may we contact?**

Name	Relationship to You	Phone

Number Employment: ☐ Full-time☐ Part-time ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled ☐ Other

Employer: ____Occupation: ____

Marital Status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

Education: 1 2 3 4 5 6 7 8 9 10 11 12 ☐ Diploma ☐ GED ☐ College/Vocational 1 2 3 4 5 6 Degree:__________________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe:__________Client Lives:
☐ Alone ☐ With immediate family ☐ With extended family ☐ With non-related

Client Lives in: ☐ Private Residence (home/apartment) ☐ Shelter/Homeless ☐ Other Residential Setting
☐ Correctional Facility ☐ Other institution setting ☐ Other: ___________________________________

Are you a Veteran? ☐ Yes ☐ No If yes, date of discharge: ____

Is the reason you are wishing to be seen at UPLIFT military related? ☐ Yes ☐ No

Have you had a diagnostic assessment completed within the past year at another mental health agency? ☐ Yes ☐ No

If yes, please tell us the agency: ____

Does a copy of your assessment need to be forwarded to someone outside of this office? ☐ Yes ☐ No If yes, please tell us:

Who:____Office:____

People Living in the same household:

Name	Age	Relationship	M/F	Employer	Phone
Name	Age	Relationship	M/F	Employer	Phone
Name	Age	Relationship	M/F	Employer	Phone

Initial:__________*I authorize UPLIFT LLC. to release necessary information to my emergency contact in the event of emergency.*

Acceptance of Financial Responsibility

Client Name:____DOB:____

By signing below as a client of UPLIFT LLC, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill a third-party insurance including Medical Assistance and Medicare. In the event that the third-party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to UPLIFT and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at the time they are received. A 10% discount is offered for full cash payment at the time of service. Billing arrangements accepted by UPLIFT other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
4. If a billing arrangement is made, a minimum payment of $60 per month or 8% of the total bill, whichever is higher, will beexpected.
5. Any services provided by UPLIFT not covered by client's insurance which are 60 days in arrears will be charged monthly penalty at a rate of 1.5% of the balance.
6. In the event of non-payment, the bill will be sent to collections.
7. UPLIFT reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.
8. The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify UPLIFT.

SPECIAL CONDITIONS:____

Charges for services are to be billed to the following sources:

☐ Insurance (primary)
Company_________________________________ Subscriber Name_________________________________
Group #_________________________________ Subscriber_________________________________
Policy #_________________________________ Subscriber Relationship_________________________________
Co-Pay Amount_________________________________ Subscriber Address _________________________________

☐ Insurance (secondary)
Company_________________________________ Subscriber Name_________________________________
Group #_________________________________ Subscriber dob _________________________________
Policy #_________________________________ Subscriber Relationship_________________________________
Co-Pay Amount_________________________________ Subscriber Address _________________________________

☐ Medical Assistance
Carrier_________________________________ MA#_________________________________

☐ EAP Provider
Name_________________________________ Number of sessions_________________________________

By signing below, I understand if coverage has lapsed, if services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize UPLIFT to furnish information to the payment sources concerning my illness and treatments and hereby assign to UPLIFT LLC all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third-party payer may inform the "subscriber" of any services billed to the payer.

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☐ **Private Pay Clients:**

Name____ Relationship____

Address____ Phone # ____

By signing below, I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

****

Client or Guardian Signature	**Date**	**UPLIFT representative**

<u>**Notice of Privacy Practices**</u>

Client Name:____ Date:__________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your nextappointment.

<u>HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU</u>

<u>**For Treatment**</u>. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, clinical business associates, or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest toyou.

<u>**For Payment**</u>. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

<u>**For Health Care Operations**</u>**.** We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

<u>**Required by Law**</u>**.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

<u>**Without Authorization**</u>. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law toreceive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.
- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.
- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.
- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.
- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.
- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.
- **Public Safety.** We may disclose your PHI if necessary, to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- **Research.** PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at UPLIFT

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI, we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protectyourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 651-493-9724, or with the MN Department of Human Services, Attn: Privacy Official, PO Box 64998, St. Paul, MN 55164-0998, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Additional Client Rights

Quality treatment:

You have the right to be treated in a professional, respectful manner. You have the right to expect quality and effective treatment.

Equal Access:
UPLIFT LLC, provides equal access to employment, programs, and services without regard to race, color, creed, religion, age, gender, disability, marital status, sexual orientation, HIV status, public assistance, criminal record or national origin.

Minor Rights:
If you are a minor, you have a legal right to request that information about you not be shared with your parents. You will need to make this request in writing, state your reasons for withholding this information, and show that you understand the consequences of doing so. In a few cases we can withhold this information without your formal request. Feel free to discuss this with your therapist.

Treatment Planning and Goals:
You have the right and responsibility to participate in helping determine your treatment plan and reaching your goals. If you feel you have not been allowed to help in this process, or that a change in counselors might be helpful to you, please advise your counselor or contact the Clinic Director.

Supplying Information:
You have the right to refuse to supply the information we request. However, without certain information, we may not be able to provide you the services you request. If you feel certain information that we request is an unwarranted invasion of privacy, please ask us for clarification.

Staff Rights:
Staff have the right:

- *To 24-hour notice when you must cancel an appointment;*
- *To courtesy and freedom from verbal abuse, harassment and threats;*
- *To preserve their personal life and to receive respect for their personal privacy;*
- *To terminate treatment or recommend a transfer if reasonable progress is not being made.*
- *To your full cooperation and participation in the therapy process;*
- *To your reliability and promptness in keeping appointments;*

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name:____ Date:_____________

Date of birth: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of UPLIFT LLC' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact UPLIFT

____ __________________

Client Signature **Date**

____ __________________

Parent, Guardian or Personal Representative Signature* **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient/Client Refuses to Acknowledge Receipt:

____ __________________

Signature of UPLIFT staff Date

UpLift LLC.
Empowering Your Journey to Wellness

Informed Consent for Assessment and Treatment

NAME:____Date of Birth: ____________________________

1. I understand that as a participant in mental health services at UPLIFT LLC (UPLIFT) I am eligible to receive a range of mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is todetermine the best course of treatment for me. Typically, treatment is provided over the course of several week, month or years.

2. I understand that all information shared with the clinicians at UPLIFT is confidential and no information will be released without my consent. During the course of treatment at UPLIFT, it may be necessary for my clinician, ARMHS Mental Health Practitioner or mental health provider to communicate with other UPLIFT staff and clinical business associates of UPLIFT. My authorization for the release of information within UPLIFT acknowledges my awareness of this communication. The purpose of this communication is to provide for continuity of care, consult on diagnosis, treatment planning or recommendations and is always done with the goal of providing the best and most appropriate services for my needs. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
   a. When there is risk of imminent danger to me or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.
   b. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
   c. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.
3. I understand that a range of mental health professionals and practitioners, some of whom may be in training, provide UPLIFT services. All professionals-in -training are supervised by licensed staff. I will be informed if the professional I am seeing is receiving supervision and is in training.

4. The Counselor-Client relationship is unique in that it is exclusively therapeutic. In other words, it is almost always inappropriate for a client and a counselor to spend time together socially, to give each other gifts, or to attend functions together. The purpose of these boundaries is to ensure that you and your counselor are clear in understanding your roles for treatment and that your confidentiality is maintained.

5. If there is ever a time when I believe that I have been treated unfairly or disrespectfully, I can discuss the situation with my mental health provider. Any issues that might interfere with the counseling process should be identified and discussed as quickly as possible. This includes personal, family, administrative, financial and other issues.

6. UPLIFT has my permission to contact me using:

Text	YES	__________ Initial	________________________________ Cellphone Number	NO	_______ initial
Email	YES	__________ Initial	________________________________ Email Address	NO	_______ initial

If I have any questions regarding this consent form or about the services offered at UPLIFT LLC, I may discuss them with my mental health provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by UPLIFT LLC. It is understood that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

____ ________________________________

Client or Legal Guardian Signature **Date**

IF CLIENT IS A MINOR: In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

____ ________________________________

Signature of client's guardian **Date**

Name of minor child:____DOB:______________

Relationship to minor child:____

UpLift LLC.
Empowering Your Journey to Wellness

Informed Consent for Assessment & Treatment
Telehealth Informed Consent

Client Name:____ Date:____________

Telehealth is healthcare provide by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I consent to engaging in telehealth with UPLIFT LLC. as part of the therapy process. I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that the telehealth sessions are not recorded but rather are set in real time between myself and the clinician.
- I understand that I may opt out of the telehealth visit at any time. This will not change my abilityto receive future care at UPLIFT LLC.
- I understand that I must take reasonable steps to protect myself from unauthorized use of myelectronic communications by others.
- I understand that all electronic medical communications carry some level or risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
  - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
  - Electronic systems that are accessed by employers, friends, or others are NOT secure and shouldbe avoided. It is important for me to use a secure network.
  - Despite reasonable efforts on the part of my healthcare provider, the transmission ofmedical information could be disrupted or distorted by technical failures.
- I understand that Skype, Face Time, or a similar service may not provide a secure HIPPAA-compliant platform, but I willingly and knowingly wish to proceed. UPLIFT LLC typically encourages and recommends the use of video for telehealth as it is a secure and encrypted telecommunication program.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that information exchanged during my telehealth visit will be maintained by healthcare providers and the agency involved in my care.
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications. Moreover, there are both mandatory and permissive exceptions to confidentiality including but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to myselfor others, or as part of legal proceedings where information is requested by a court of law.
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medicalrecords).
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealthvisit.

- I understand that I have a responsibility to verify the identify and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcareprovider.

- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a client, I agree to accept responsibility for following my healthcare providers recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that there is never a warranty or guarantee as to a particular result of outcome related to acondition or diagnosis when medical care is provided. Furthermore, I understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and the efforts of my therapist, my condition may not improve, or may have the potential to get worse.
- To the extent permitted by law, I agree to waive and release my healthcare provider andhis/her institution or practice from any claims I may have about the telehealth visit.
- I understand the inherent risks of errors or deficiencies in the electronic transmission orhealth information and images during a telehealth visit.
- **I understand that electronic communication cannot be used for emergencies or time sensitive matters. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. I understand that emergency situations include but are not limited to: thoughts about hurting/harming myself or others, having uncontrolled psychotic symptoms, if I am in a life-threatening situation, and/or if I am abusing drugs or alcohol and am not safe.**

I certify that I have read and understand this agreement and that I have had the opportunity for questions to be answered to my satisfaction.

For electronic communication between UPLIFT LLC.and ______________________________

Client's Printed Name

______________________________ ______________________________

Client or Legal Guardian Signature Relationship to Client

______________________________ ______________________________

Email Address Date

RELEASE OF INFORMATION

Patient Information

Name:______________________________Date of Birth:__________________

Address:____

City:____________________State:__________Zip:__________Phone: ______________

I authorize

UPLIFT LLC

2147 University Ave W, STE 101St Paul, MN 55114

O: 651-493-9724 | C: 614-377-6867 nfarah@uplifthealthmn.com www.uplifthealthmn.com

To do the following:

☐ **Release to** ☐ **Receivefrom**

Agency/Name:____

Address:________________________City:______________State:________Zip:__________

Information to be Released: (Please check the appropriate box)

☐ Most Recent Diagnostic Assessment ☐ Diagnostic Assessment, 3 most recent Progress Notes & Treatment Plan ☐ Most Recent Treatment Plan
☐ Psychological Testing Interpretive Report ☐ All Medical Records ☐ Other:

Methods of Communication: (Please check the appropriate box)

☐ Fax ☐ Mail ☐ Secure Email ☐ Pick Up ☐ E-mail Address: nfarah@uplifthealthmn.com

Purpose of Release: (Please check the appropriate box)

Note: Records sent to a third party must identify the purpose

☐ Personal Use/Review ☐ Insurance Payment ☐ New Service Provider ☐ Litigation/Legal ☐ Other__________________

Comment:____

Initial Action (What would you like done with the release)	☐ **Keep on File** For Future Use	☐ **Send Record** To Agency Listed Above

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken UPLIFT LLC Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I release UPLIFT, its employees and agents, nursing staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires.

Client Signature:____Date: ________________

Legal guardian/Responsible Party Signature:__________________________Date:________________

Name (If not signed by the client):______________________________Relationship:________________

NOTE: If signed by someone other than the patient, we need written proof of authority.

DO NOT FORWARD TO ANOTHER PERSON/AGENCY WITHOUT PATIENT WRITTEN CONSENT

01/2025 © UPLIFT LLC.

For internal Use: Faxed Date: Initials:

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