LifeStance Health, Inc.
Consent to Disclose Substance Use and Mental Health Patient Records
School-Based Release of Information

Client Name: _____ Date of Birth: _____
Other Names Used in Treatment, if any: _____

I authorize LifeStance Health, Inc. ("LifeStance") to exchange information regarding my treatment and participation in LifeStance's School-Based Program to:

My (Child's) School: _____ Fax: _____
My (Child's) School District: _____ Fax: _____

Mark all types of alcohol and drug or mental health information to be disclosed to above party/from the above party:
Treatment Related:
☐ To verify treatment dates/discharge status
☐ SUD and MH Evaluation and recommendations
☐ Progress to treatment
☐ Medications, lab information and results
☐ Progress updates
☐ Other (specify): _____

How much of the information can be shared (specify date range, specific note, specific type of documentation, etc.): _____

Purpose for the disclosure of the above information authorized herein is to: (Initial and write specific reason)
☐ Coordination of care ☐ Other (specify): _____

If not previously revoked, this consent will terminate upon: (specific date, event, or condition)
☐ On this date: _____
☐ One year from the date of my signature, or
☐ 45 days after completion of course of treatment and/or payment in full for services provided

I understand that:
I understand that I am not required to sign this authorization. If I refuse to sign this, LifeStance may not condition treatment, payment, enrollment, or eligibility of benefits. The only exception is if the services I am seeking fare only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If LifeStance has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form from the LifeStance front office of the facility I treat at or my provider and return

the completed form to my provider or the front office. I can also provide a written notice of my revocation to my LifeStance provider or to the front office.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I understand I have the right to receive a copy of this request.

Client Signature: _____

Date: _____

If personal representative, type in name: _____

Personal Representative Signature: _____

Date: _____

Witness: _____

Date: _____

The information has been disclosed to you from records protected by Federal confidentiality (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFS part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.