

Mary Byrd, LMHP
1710 North 144th St.
Omaha, NE 68154
Telephone 402-651-4673 Fax 402-614-6174

I hereby authorize _____ and _____ and _____

Street Address: _____ City/State: _____ Zip: _____

Phone: _____ Fax: _____ to release and/or receive information about:

Name: _____ DOB: _____ SSN: _____

Description of Information to be Disclosed

- | | |
|--|---|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Nursing/Medical Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Toxicological Reports/Drug Screens |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Discharge/Transfer Summary |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medication Management Information | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Presence/Participation in Treatment | |
| <input type="checkbox"/> Reciprocate information written or verbal | |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Mary Byrd, LMHP. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____.

Conditions

I further understand that Mary Byrd, LMHP will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date

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

Check here if patient/client refuses to sign authorization

Signature of Staff Witness Date