Omaha Psychotherapy

6910 Pacific Street, suite 320
Omaha, NE 68106

(402) 715-9710
omahapsychotherapy.com

Release of Information

I, _____ (name of client), whose date of birth is _____, authorize Omaha Psychotherapy to disclose to and/or obtain information from: _____for the following reasons:

Description of information to be disclosed:

__ Assessment
__ Diagnosis
__ Psychosocial Assessment
__ Psychological Evaluation
__ Psychiatric Evaluation
__ Treatment Plan or Summary
__ Current Treatment Update
__ Medication Management Information
__ Presence/Participation in Treatment
__ Nursing/Medical Information
__ Educational Information
__ Discharge/Transfer Summary
__ Continuing Care Plan
__ Progress in Treatment
__ Demographic Information
__ Other_____

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 Omaha Psychotherapy at 6910 Pacific Street, suite 320, Omaha, NE 68106. 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 Hannah Mirmiran, LCSW 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.

Redisclosure:
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

_____

(Signature of Client) (Date)

_____

(Signature of Parent, Guardian or Personal Representative) (Date)

_____

(Authority to act for this individual: power of attorney, healthcare surrogate, etc.)

_____Check here if client refuses to sign authorization

_____

Signature of Staff Witness Date