A Counseling Center, P.C.
www.kevinfitzmaurice.com
3323 North 109th Plaza, Omaha, NE 68164-2908
Phone: 402.573.7277 Fax: 402.573.7360

AUTHORIZATION FOR THE RELEASE OF INFORMATION

NOTICE TO AGENCY/PERSON RECEIVING MENTAL HEALTH INFORMATION: The mental health information that accompanies this release has been disclosed and may only be disclosed pursuant to the written authorization of the client or the client's legal representative. Any unauthorized disclosure of mental health information is unlawful and is subject to civil damages and criminal penalties. Federal Regulation 42 CFR, Part 2 prohibits making further disclosure of this confidential information without the specific written consent of the person to whom it pertains. NOTE: If this release was received in error—return immediately to the above address.

REGARDING: _____
Client Name (print or type) Date of Birth Social Security Number

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE A COUNSELING CENTER, P.C. TO:

Check One: ❑ Exchange With (2-way) ❑ Obtain From (in only) ❑ Release To (out only)

_____
*****MEDICAL** Receiver of Release: A medical **doctor**'s name and-or a medical **clinic** or **hospital**'s name*****

_____
Street Address City State Zip Area Code Phone Number

THE FOLLOWING INFORMATION: (choose only those needed but often the first 4)

❑ ALL Medical: diagnosis, prognosis, evaluations, tests, treatments, medications, blood levels, and lab or pharmacy reports.
❑ ALL Psychiatric: diagnosis, prognosis, evaluations, opinion, medication checks, clinical notes, and discharge/treatment summary.
❑ ALL Psychological: diagnosis, prognosis, evaluations, test results (both formal and informal), and discharge/treatment summary.
❑ ALL Therapeutic: intake, social history, treatment plans/updates, progress notes, staffing notes, and discharge/treatment summary.
❑ ALL Educational: transcripts, test results, student evaluations, intelligence tests, IQ scores, learning disability testing and reports.
❑ Other: _____.

THIS AUTHORIZED RELEASE IS REQUESTED FOR THE FOLLOWING PURPOSE(S):

❑ Referral for services and-or treatments.
❑ Assistance in assessment, evaluation, diagnosis, and-or treatment planning.
❑ Case consultation, case coordination, case monitoring, case management, and-or case collaboration.
❑ Managed-care company's and-or insurance provider's screenings, case reviews, utilization reviews, and service authorizations.
❑ Other: _____.

THIS RELEASE IS RESTRICTED TO THE FOLLOWING FORMS OF INFORMATION:

❑ Not Restricted in Form or Media ❑ Written ❑ Verbal ❑ Audio ❑ Video ❑ Electronic

THIS AUTHORIZED RELEASE OF INFORMATION WILL EXPIRE:

❑ 90 days following the termination of ALL of my services (therapeutic or administrative) at A Counseling Center, P.C.
❑ On the specified date (month, day, year) that immediately follows on this line: _____

FOUR IMPORTANT POINTS REGARDING THIS AUTHORIZED RELEASE:

1. I understand I have the right to request an inspection of the written information that will be released through this authorization and that **if** such an inspection occurs, it will occur in a meeting with my counselor or another professional employed by this agency.
2. I understand that I may revoke this authorization at any time by providing a written revocation to A Counseling Center, P.C. I understand that any release of information that was made prior to my written revocation of this release, which was made in reliance upon this authorized release of information, shall not constitute a breach of any of my rights to confidentiality.
3. I understand that if the person or organization that receives my information is not either a health-care provider or a health-care insurer that my information may no longer be protected by Federal privacy regulations.
4. I understand that either a facsimile or photocopy of this authorized release shall be deemed as valid and effective as the original.

_____ _____
Parent or Guardian's Signature or N/A Date Signed Relationship to Client of Parent or Legal Guardian or N/A

_____ _____
Client's Signature Date Signed Witness's Signature Date Signed

In order for ALL information (Drug, Alcohol, HIV, AIDS) to be released, you must sign again below.

I DO HEREBY AUTHORIZE THE RELEASE OF SPECIFIC INFORMATION REGARDING:

❑ DRUG/ALCOHOL ABUSE/USE INFORMATION ❑ DRUG/ALCOHOL TREATMENT INFORMATION
❑ HIV/AIDS RELATED INFORMATION ❑ HIV/AIDS TREATMENT INFORMATION

I understand that the information to be released MAY INCLUDE material that is protected by Federal Law and that is applicable to EITHER Drug/Alcohol or HIV/AIDS related information or BOTH. My signature authorizes the release of all such checked information.

_____ _____
Parent or Guardian's Signature or N/A Date Signed Relationship to Client of Parent or Legal Guardian or N/A

_____ _____
Client's Signature Date Signed Witness's Signature Date Signed