8101 O St. STE 300 Lincoln, NE 68510
Phone: 402.261.3714 Fax: 1.888.959.0716

Release of Information: for independent ADULTS

This release is valid for one year from date of signature and may be revoked in writing at any time.

Printed Client Name: I, _____Day of Birth: _____

Hereby authorize therapist:_____

Name *Credentials*

To:

_____RELEASE the initialed information about the above person **TO**:

_____RECEIVE information about the above person **FROM**:

Name: _____

Agency: _____

Address: _____

Phone: _____Fax:_____

Information to be released or exchanged:

_____Verbal Communication RE: Coordination of Care
_____Written Communication RE: Coordination of Care

_____Mental Status	_____Family Systems eval.	_____Background & History
_____Psychological eval.	_____Educational Tests	_____Psychiatric Evaluation
_____Discharge summary	_____Attendance Records	_____Medication Dosage(s)
_____Diagnosis	_____Court Documents	_____Physician Recomm.
_____Psychosocial Record	_____Consultation Reports	_____Nursing Notes
_____Therapists Orders	_____Crisis Intervention	_____Lab Results
_____Treatment Plans	_____Agency Documents	

Other (Specify): _____

Signature: _____Date:_____

Witness Signature: _____Date: _____