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Release of Information: for Minors and Those with Guardians

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

Name of Minor or Person with a Guardian: _____ Day of Birth: _____

Printed Guardian/Parent Name: I, _____ Day of Birth: _____

Hereby authorize therapist: _____

Name

Credentials

To:

_____ RELEASE the initialed information about the above person **TO:**

_____ RECIEVE 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: _____