

Spence Counseling Center, P.C.
12035 Q Street
Omaha, NE 68137

Release of Confidential Information
(Protected Health Information)

Re: (Client) _____ **Date of Birth** _____

I authorize Counselor _____ to

___ Release information to: ___ Receive information from: ___ Exchange information with:

Name: _____

Information will include:

___ Diagnosis, treatment plan, progress, prognosis and recommendations	___ Admission and discharge summary
___ Treatment summary	___ Social history
___ Medications, current, and past	___ Psychological evaluation
	___ Other _____

Note: Psychotherapy (Session) notes may not be included in this authorization along with any other protected health information.

The reason for releasing this information is:

___ Coordination of care	___ Other: _____
___ At the request of the client (This is all that is necessary if you do not want to state a specific reason.)	_____

This authorization will remain in effect until:

(date) _____
or until (event related to the person or the purpose of this disclosure) _____

I may end this authorization at any time by notifying the above counselor at Spence Counseling Center in writing. However, that will not effect any actions taken before receipt of that notice.

Signature of Client

Date Signed

Signature of Parent/Guardian/Witness

Date Signed