Spence Counseling Center, P.C.
12035 Q Street
Omaha, NE 68137
Phone (402) 991-0611 Fax (402) 991-6228

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: _____ **Phone:** _____

Fax: _____ **E-mail:** _____

Information will include:

_____ Diagnosis, treatment plan, progress, prognosis and recommendations
_____ Treatment summary
_____ Medications, current, and past
_____ Admission and discharge summary
_____ Social history
_____ 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
_____ At the request of the client
(This is all that is necessary if you do not want to state a specific reason.)
_____ Other: _____
_____

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