

**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:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**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

*Spence Counseling Center, P.C.*  
*(402) 991-0611*