CLEARWATER COUNSELING, PC

MENTAL HEALTH SERVICES

Authorization for the Release of Protected Health Information

Patient Name: _____ Date of Birth: _____
Address (including City/State/Zip)_____
_____
Phone Number: _____ Email _____@_____

Release Information From:	**Release Information To:**
Provider/Facility Name: _____	_____
_____	_____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax _____	Phone: _____ Fax _____
	Email: _____

Information to be Released: **Service Dates:** From: _____ To: _____

	Clinic				Hospital		Ancillary		Other
☐	Allergy	☐	Neurology	☐	Anesthesia Records	☐	CT/MRI	☐	Immunization Record
☐	Audiology/Cochlear	☐	Ophthalmology	☐	Behavioral Health/IRTC	☐	EEG	☐	Itemized Billing Records
☐	Craniofacial	☐	Orthopedic	☐	Consultation Reports	☐	EKG	☐	Nutrition
☐	Ear, Nose, Throat	☐	Pediatric	☐	Discharge Summary	☐	Lab	☐	School/Work Release
☐	GI	☐	Psychiatry	☐	History & Physical	☐	Sleep Study	☐	Verbal Communication
☐	Internal Medicine	☐	Speech & Language	☐	Operative Report	☐	X-ray		
Other:									

Purpose for which information is to be used:

☐ Treatment/Referral ☐ Insurance ☐ Evaluation
☐ Changing Doctors ☐ Personal/At Request of Patient ☐ Other (Please specify)

State and federal law protect the following information. Please check the box if you want to include this information with your records.

☐ Alcohol, Drug, or Substance Abuse Records ☐ HIV Testing & Results

Release Format: ☐ Paper ☐ CD/DVD **Release Method:** ☐ Mail ☐ Pick up ☐ Fax ☐ Email ☐ Portal

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Clearwater Counseling, PC at 7701 Pacific St., Suite 100A, Omaha, NE 68114 OR Clearwater Counseling, PC at 312 N. Elm St., Suite 112, Grand Island, NE 68801. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one year from the date signed or on the following date/event/condition of outpatient mental health services, whichever occurs sooner.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date