Great Oaks
COUNSELING LLC

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Omaha, Nebraska 68144
Phone 402-932-6500 Fax 402-932-6504

Release of Confidential Information
(Protected Health Information)

Regarding: _____ Date of Birth _____
Client's Name (print or type)
Address: _____

I authorize _____ to
(Behavioral health provider)

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

_____ _____
Name and Identifying Relationship to client (ex. teacher, physician, mother) Phone

_____ _____
Address Fax Number

My signature indicates that I understand my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions. I authorize the release/exchange of the following information (check all that applies):

___Diagnosis, Progress, Prognosis & Recommendations
___Alcohol/Substance Assessment/ Treatment/Recommendations
___Psychotherapy Notes (notes taken during session)
___Admission & Discharge summary
___Social History
___Joint session
___Treatment summary
___ Attendance in Treatment
___Psychiatric Evaluation (may include all of the above)
___Medications Past/Current
___Evaluations
___Progress Notes
___HIV/AIDS
___Other:_____

The reason for releasing this information is:
___ Coordination of care ___ At the request of the client ___ Other: _____

This authorization will expire 1 year from the date of signature below unless revoked prior to that date:

- You may revoke this authorization at any time by notifying the above behavioral health provider at Great Oaks Counseling, LLC in writing. However, revoking this authorization in writing will not affect any actions taken before receipt of that notice.
- The information disclosed based on your signed authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- You do not need to sign this form in order to obtain services from Great Oaks Counseling, LLC.
- This authorization is completely voluntary, and you do not have to agree to authorize any disclosure.
- You have a right to a copy of this authorization once you have signed it.

_____ _____ _____ _____
Signature of Client/or Parent if Minor/Guardian Date Signed Witness Date Signed

Notice To Recipient of Information:

This information has been disclosed to you from records which may be protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.