Compassionate Minds Therapy LLC
11580 Dodge Street, Omaha NE 68114
Voice: 402-238-1431 Fax:402-281-1862 Email:admin@compassionatemindstherapy.com

Authorization for Release of Protected Health Information

My Name (Client)_____My Date of Birth:_____

Address:_____

City:_____State:_____Zip:_____

I authorize_____to communicate with the following:

Name/Organization:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____Email:_____

I Authorize the Information Release in order to:
☐ Receive Information from Compassionate Minds Therapy LLC
☐ Provide Information to Compassionate Minds Therapy LLC
☐ Both Receive and Provide Information

The specific type and amount of information to be used or disclosed is as follows:

☐Complete record	☐Substance abuse evaluation	☐Attendance and Compliance
☐Initial evaluation	☐Psychological Evaluation	☐Treatment plan
☐Psychiatric evaluation	☐Substance Abuse diagnosis and treatment	☐Progress Notes
☐Educational records	☐Medical/Health	☐HIV/AIDS Status

The reason for this disclosure is:_____

I am authorizing the release of confidential information that is to be used in conjunction with the professional services I am receiving. I understand that no services will be denied to me solely because I refuse to consent to the release of information. I understand that I am not required in any way to sign this release.

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or canceled by me in writing or until
(date)_____(not more than 90 days if one time disclosure or not more than 12months if ongoing disclosure)

I acknowledge that I was offered a copy of this release. A copy of this authorization is as good as the original.
I understand that the records released may include drug and alcohol related information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent. **I understand that the records released may include drug and alcohol related information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent.**

_____ _____
Print Legal Name Parent / Guardian Signature

_____ _____
Sign Legal Name Date Signed

_____ _____
Witnessed by Date Signed

Relationship to patient/client (✓ Check one box): ❑ - self ❑ - parent ❑ - legal guardian