



PSYCHOLOGICAL & COUNSELING SERVICES, PC

Offering a Full Range of Psychological & Counseling Services

HIPAA AUTHORIZATION

BY SIGNING THIS FORM, YOU PERMIT THE HEALTH CARE PROVIDER IDENTIFIED BELOW TO DISCLOSE YOUR CONFIDENTIAL PERSONAL HEALTH INFORMATION

1. **PATIENT.** The patient whose information may be released is:

NAME _____ DOB _____
ADDRESS _____ CITY, STATE, ZIP _____
PHONE _____

2. **PERSONAL HEALTH INFORMATION.** Disclose the following personal health information (check as applicable):

- Summary of previous mental health assessment and treatment
- Psychiatric information
- Summary of substance abuse assessment and treatment
- Medical history, physical examination, laboratory, or x-ray data
- Psychological test information
- School information including transcripts, tests, and anecdotal records
- The following information: _____

3. **DISCLOSING PROVIDER.** The following provider(s) may disclose the personal health information:

Provider: _____
Address: _____ City, State, ZIP _____
Phone: _____ Fax: _____

4. **RECIPIENT.** The following persons/ organizations are to receive the personal health information:

Name: _____ of **Psychological & Counseling Services, PC**
Address: **12728 Augusta Ave, Ste. 150** City, State, ZIP: **Omaha, NE 68144**
Phone: **(402)330-1537** Fax: **(402)330-9331**

5. **PURPOSE OF DISCLOSURE.** The reason I am authorizing release is:

My request Other (describe) _____

6. **EXPLANATION OF RIGHTS:** I understand that I can revoke this Authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization. The authorization expires 180 days after it is signed.

I understand the disclosing provider may not condition treatment on my willingness to sign this authorization.

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

Signature of Patient or Personal Representative

Date

Representative's Relationship to Patient

Representative's Printed Name