



Mental Health Treatment Release of Information

I, _____ [Client name], whose Date of Birth is _____,

authorize River Cairn Counseling to disclose to _____ and/or obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed

(Client should initial each item to be disclosed)

- | | |
|---|-----------------------------------|
| _____ Assessment | _____ Nursing/Medical Information |
| _____ Diagnosis | _____ Educational Information |
| _____ Psychosocial Evaluation | _____ Discharge/Transfer Summary |
| _____ Psychological Evaluation | _____ Continuing Care Plan |
| _____ Psychiatric Evaluation | _____ Progress in Treatment |
| _____ Treatment Plan or Summary | _____ Demographic Information |
| _____ Current Treatment Update | _____ Psychotherapy Notes* |
| _____ Medication Management Information | _____ Other _____ |
| _____ Presence/Participation in Treatment | _____ Other _____ |

(*Cannot be combined with any other disclosure)

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date (No more than 1 year from today's date): _____ or as otherwise indicated: _____



Conditions

I further understand that River Cairn Counseling will not condition my treatment on whether I give authorization for the requested disclosure, except for if the purpose of the treatment is solely to create protected health information (PHI) for disclosure to a third party (e.g., a fitness for duty evaluation). However, it has been explained to me that failure to sign this authorization may have the following consequences:

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the PHI that is disclosed pursuant to this authorization may be redisclosed by the recipient. I understand that River Cairn Counseling is not responsible for the redisclosure of PHI by the recipient.

I will be given an electronic copy of this authorization for my records. If I would like a physical copy, I will provide written request to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512.

Signature of Patient/Client	Date
-----------------------------	------

Signature of Parent, Guardian or Personal Representative	Date
--	------

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Check here if patient/client refuses to sign authorization

Signature of Counselor	Date
------------------------	------