Vickie DeBuhr, MS, LMHP
Keystone Counseling Solutions LLC

Release of Information

By signing this document, you permit the health care provider identified below to disclose our confidential, personal health information.

Client: Name of client whose information may be released.

NAME:_______________________________________DOB______________________________

ADDRESS:______________________________CITY________________STATE_____

Zip_____________PHONE #____

Personal Health Information: I consent to disclose the following personal health information (check applicable items).
☐ My entire counseling record ☐ My billing record
☐ Only the following specific records and treatment__________________________________

Provider A:
Name: **Vickie DeBuhr, MS, LMHP** (Keystone Counseling Solutions LLC)
Address: 1406 Fort Crook Rd S Bellevue NE 68005
Fax # 402-292-0144

Provider B:
Name: ____
Address: ____
Phone:___________________________FAX____

Please initial the option below that specifies your request to release information:
_____Option #1 Consent to reciprocal release of information **between** Provider A and B
_____Option #2 Consent to release of information from Provider A to Provider B
_____Option #3 Consent to release of informations from Provider B to Provider A

Expiration of Consent to Release Information:
Date:_____________________________ or End of Treatment________________________

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 disclosing provider /plan may NOT condition treatment, enrollment in the health plan, or eligibility for benefits on whether I sign this Authorization.
→I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer protected by state or federal law.

____ ____________________________________
Signature of Patient or Legal Guardian Date

(5/18)