



5550 S. 59th St.
Suite 11
Lincoln, NE 68516

www.daringmindstherapy.com
maureen.deryke@daringmindstherapy.com
erica.schroeder@daringmindstherapy.com

p. (531) 289-1005
f. (531) 289-1002

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

Date of Records Request: _____

Client: _____ Date of Birth: _____

Client Address: _____

Client Phone: _____

Reason for Request: _____

If transferring, why? _____

I authorize Daring Minds Therapy, LLC to send and / or receive information from:

Individual/Agency Name: _____ Contact Person (if applicable) _____

Relationship (e.g., attorney, physician, family member, school, etc.): _____

Phone _____ Secure Email _____

Address _____ Fax _____

PURPOSE OF DISCLOSURE

- Coordination of care Legal/court-related matter Family involvement/support
- School/academic coordination Emergency contact Other: _____

Records authorized to be released (please initial each box as appropriate)

- Attendance and participation in services Evaluation Report Medical History
- Legal Record Discharge Summary Progress Notes Psychological Testing
- Diagnosis Treatment plan Progress summaries
- Written and verbal communication for coordination purposes
- Other (specify): _____

This authorization is limited to the information necessary for the purpose identified above, consistent with applicable federal and state confidentiality laws.

Release of full clinical records requires additional, specific written authorization unless otherwise required or permitted by law.

Client Rights, Confidentiality, and Authorization Acknowledgment

I understand that my health information may include sensitive information related to mental health services and/or treatment related to alcohol or drug use.

I understand that information related to alcohol or drug use is protected under federal law (42 C.F.R. Part 2), which provides additional confidentiality protections. This information will not be disclosed without my written authorization except as permitted or required by federal or state law.

I understand that I may revoke this authorization at any time by submitting a written request. Revocation will not apply to any information that has already been disclosed prior to receipt of my written request.

This authorization will expire one year from the date of signature unless otherwise specified. A photocopy of this authorization shall be considered as valid as the original.

Parent/Guardian/Personal Representative (if applicable)

<i>Signature of Client</i>	<i>Printed Name</i>	<i>Date</i>
----------------------------	---------------------	-------------

Parent/Guardian/Personal Representative (if applicable)

<i>Signature</i>	<i>Printed Name</i>	<i>Date</i>
------------------	---------------------	-------------

Relationship to Client

Witness

<i>Signature</i>	<i>Printed Name</i>	<i>Date</i>
------------------	---------------------	-------------