

Lincoln Therapy 1620 S 70<sup>th</sup> St. Suite 100 Lincoln, NE 68506  
Fax 402.904.4905

### Release of Information

Authorization to Release and/or Receive Healthcare Information

- Michelle Miller, LIMHP, CPC, CTPP ph. 402.450.5288 michelle@lincolnthrapy.com
- Kelly Rook, LIMHP, CTPP ph. 402.770.2969 kellyrook@lincolnthrapy.com
- David Sullivan, LADC, PLMHP ph. 402.202.9342 davidlsullivan@protonmail.com

Regarding/name: \_\_\_\_\_ DOB \_\_\_\_\_

Name of Intended Receiver/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ fax: \_\_\_\_\_

\_\_\_\_\_ Verbal Communication \_\_\_\_\_ Written Communication

Billing and Scheduling	Psychiatric Assessment & Update	Progress
Mental Status/MSE	Crisis Intervention	Drug/Alcohol Evaluation
Discharge Summary	Treatment Plan & Update	Medication Administration
Diagnosis	Psychosocial Assessment & Update	Agency Documentation
Phone Communication	Educational Testing	Background & History
Physical Examination	Lab Results	Collaboration of Care
Physicians Orders	Court Orders	Prescription Information
Therapists Orders	Consultation Reports	Other:

This signed release of information (unless revoked in writing) shall terminate 90 days from the date of discharge or one year from the date of signature, whichever is the latter. By signing this release and authorization, I acknowledge that the information to be release may include material that is protected by Federal Law and may contain Personal Health Information. My signature authorizes release of all such information. I also understand that this authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that if the person/organization authorized to receive my information is not a health plan or a health care provider, the released information may no longer be protected by Federal Privacy Regulation. A photocopy, scan or fax of this document shall have the same effect as the original copy. By signing this document, I release above checked practitioner(s) from any liability resulting from this disclosure.

Self/guardian  \_\_\_\_\_ date: \_\_\_\_\_

Witness: \_\_\_\_\_ date: \_\_\_\_\_