Deedee Shaw LICSW
330 North 48th St, Suite A
Lincoln, NE 68504-3515
Phone 402-326-9168

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

Client name _____ Date of Birth _____

This form provides (Provider)_____Diedre Shaw_____ written permission to communicate with other individuals and professionals involved in your treatment (primary care physicians, previous therapists, other health care providers, family members, etc) and allows for coordination of care on your behalf.

Name / Facility Name _____

Address _____

Phone _____ Fax _____

Please provide all reports below

(Cross off any reports you DO NOT want released)

Background and History	BioPsychoSocial Assessment	Complete Treatment Record
Communication and Contact	Consultation Reports	Court Orders
Crisis Intervention Plan	Diagnosis	Discharge Summary
Drug and Alcohol Evaluation	Educational Testing	Family Systems Evaluation
Individualized Education	Medication and Dosages	Mental Status Exam
Physician's Orders	Psychological Evaluation	Progress Notes
Treatment Plans	Other	

By signing this form, I authorize the disclosure of written / verbal information.

Client Signature _____ Date _____

Guardian Signature _____ Date _____

Relationship to Client _____

Witness Signature _____ Date _____