AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ **Date of Birth**: ____/____/_____

I hereby authorize the exchange of Protected Health Information between:

The Insight Program AND	Name: _____
	Office:_____
7501 O Street Suite 100	Address: _____
Lincoln, NE 68510	City: _____ State: _____
Phone: (402) 477-0651	Phone: (_____) _____-_____
Fax (402) 477-0332	Fax: (_____) _____-_____

Information to be exchanged: □ Attendance Record □ Entire Record □ Progress Notes

□Psychiatric/Psychological Evaluation □ Health History/Status □ Other _____

Reason for Disclosure:

The validity of this release will extend for a period of one year from the signature date. An electronic or faxed copy of this authorization is valid.

Clients may revoke an authorization to release information at any time by sending written notification. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ Date: ____/____/_____ **Client Signature/Parent (if Minor)/Guardian**

_____

Printed Name