



Tara L. Thomsen, LIMHP, CPC
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AUTHORIZATION TO RELEASE, OBTAIN, OR EXCHANGE INFORMATION

I hereby give permission to ___ release, ___ exchange, or ___ obtain information regarding (client's name) _____ (date of birth) _____ to be used for the purpose of _____ . The specific information (checked below) is to be disclosed by (or exchanged between):

Tara Thomsen LMHP
 11060 Oak Street Suite 2
 Rockbrook Village
 Omaha, NE 68144
 Ph. 402-933-8998
 Fax. 402-933-9091

To (and): Person or facility _____
 Address _____

 Phone _____ Fax _____

I authorize the release or exchange of the following kinds of information:

- Summary of assessment and treatment
- Summary of substance abuse assessment and or treatment information.
- Psychological testing information
- Educational Evaluation
- All available information
- The following information _____

I understand that I am authorizing the release of confidential information. This statement of consent can be revoked in writing at any time before disclosure of the information and shall remain in effect until withdrawn or cancelled by me in writing. I understand that treatment cannot be conditioned on my willingness to sign this authorization and I also understand that this information will not be disclosed to another party without my written consent.

 Signature Printed Name Rel. to Client Date

 Witness Printed Name Date