Authorization to Release and/or Receive Healthcare Information

Name of Patient: _____

Address: _____

Date of Birth: _____

I request and authorize KLR Counseling to (check one):

____ Obtain information from
____ Send information to
____ Obtain AND send information to/from

Name of Health Care Provider/Agency/Person:

_____

Address and Phone/Fax

_____

Information requested to be released (check all that apply):

____ Entire Record ____ Diagnostic Evaluation ____ Treatment Plan
____ Progress Notes ____ Psychological Testing ____ Treatment Summary
____ Medical History/Medications ____ Discharge Summary ____
Other_____

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. **I understand this authorization will expire 1 year from the date signed or until _____.**

I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. By signing this document, I release KLR Counseling, LLC, from any liability resulting from this disclosure. I understand I have a right to receive a copy of this authorization. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at KLR Counseling, LLC. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original.

_____

Signature of Patient/Legal Representative

_____

Witness

_____

Date document signed

KLR Counseling, LLC
Kipp Ransom, LIMHP, LPC
2001 Pine Lake Road, STE 200 Lincoln, NE 68512
Phone (402) 261-8313 Fax: (866)321-6448
Creating Positive Change