Release of Information to/ from Primary Care Physician or Other Behavioral Health Clinician/Facility

Client/Patient

Name: _____ DOB:_____

Primary Care Physician or other Behavioral Health Clinician/Facility

Name: _____ Office or Facility: _____

Phone: _____ Fax: _____

Address: _____

(Street) (City) (State) (Zip)

Psychological & Counseling Services Clinician

Name: _____ Phone:_____

Note: <u>PLEASE DO NOT SEND MEDICAL RECORDS UNLESS SPECIFICALLY REQUESTED.</u>

Consent to Release Information

Communication between behavioral health providers and your primary care physicians or other behavioral health providers is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary.

Release—P&CS to Outside Physician/ Clinician

I authorize Psychological & Counseling Services (P&CS) to release information related to (my/ my child's) evaluation and treatment to the physician/clinician named above. This consent will last six months from the date signed. I understand that I may revoke this consent at any time, provided such revocation be offered in writing.

_____

Responsible Party's Signature Printed Name of Signee Date

Release— Outside Physician/ Clinician to P&CS

I authorize the physician/clinician named above to release information related to (my/ my child's) evaluation and treatment to Psychological & Counseling Services (P&CS). This consent will last six months from the date signed. I understand that I may revoke this consent at any time, provided such revocation be offered in writing.

_____

Responsible Party's Signature Printed Name of Signee Date

Release of Information to/ from School or other Educational Representative/ Facility

Client/Student
Name: _____ DOB:_____

School Name:_____ ***Specific Personnel, if any:_____***
Phone: _____ Fax: _____
Address: _____
(Street) (City) (State) (Zip)

Psychological & Counseling Services Clinician
Name: _____ Phone:_____

Note: PLEASE DO NOT SEND EDUCATIONAL RECORDS UNLESS SPECIFICALLY REQUESTED.

Consent to Release Information
Communication between behavioral health providers and educators is important to help ensure comprehensive and quality health care. This information will not be released without your consent. This information may include testing results, educational history, diagnosis, treatment plan, progress, and medication if necessary.

Release—P&CS to School Representatives
I authorize Psychological & Counseling Services (P&CS) to release information related to (my/ my child's) evaluation and treatment to the school/representatives named above. This consent will last six months from the date signed. I understand that I may revoke this consent at any time, provided such revocation be offered in writing.

_____
Responsible Party's Signature Printed Name of Signee Date

Release— School Representatives to P&CS
I authorize the school/representatives named above to release information related to (my/ my child's) educational performance and history to Psychological & Counseling Services (P&CS). This consent will last six months from the date signed. I understand that I may revoke this consent at any time, provided such revocation be offered in writing.

_____
Responsible Party's Signature Printed Name of Signee Date

Psychological & Counseling Services, PC 12728 Augusta Ave., Ste. 150 Omaha, NE 68144
402.330.1537 (office), 402.330.9331 (fax)