Focus Therapy
A West Omaha Counseling Practice

Become the Optimal You

Release of Information
3520 N. 163rd Plaza Suite #6 | Omaha, NE | 68116
p. 402.513.4416 becky@focustherapyomaha.com

Client Name:_____ Date of Birth_____
Address (street, city, state, zip) _____

I hereby authorize: Focus Therapy and my therapist Becky Meline, LIMHP, LISW, IADC
And

Name _____
Address _____
Phone_____ Fax_____
Relationship to client _____

TO DISCLOSE TO AND COMMUNICATE TO ONE ANOTHER information contained in my patient/student records, including if any, alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Par 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA); social services records; psychological services records, including communications made by me to a social worker or psychologist; only under the conditions listed below:

SPECIFIC INFORMATION TO BE DISCLOSED

☐ ASSESSMENT/DIAGNOSIS	☐ PROGRESS REPORTS	☐ REAUTHORIZATION FORMS
☐ COMMUNICATION EXCHANGE	☐ RECOVERY PLAN	☐ OTHER PERTINENT INFORMATION (Specify)_____
☐ PSYCHOSOCIAL/COUNSELING	☐ DISCHARGE SUMMARY	_____
☐ TREATMENT PLAN/CONTRACT	☐ DR. DISCHARGE SUMMARY	_____
☐ LAB RESULTS	☐ _____	_____
☐ ADMISSION/DISCHARGE DATA SET	☐ _____	_____
☐ SCHOOL/WORK RECORDS	☐ _____	
☐ SCHOOL/WORK SOCIAL INVOLVEMENT	☐ _____	Dates of Service_____

PURPOSE AND NEED FOR SUCH DISCLOSURE

☐ CONTINUATION OF CARE	☐ _____	☐ RETURN TO SCHOOL/WORK
☐ SCHOOL/WORK	☐ _____	☐ OTHER (Specify)_____
☐ REFERRAL FOLLOW-UP	☐ _____	_____
☐ FAMILY NOTIFICATION		

I understand that my medical record may contain reports, test results and notes that only a care provider can interpret. I understand and have been advised that I should contact my care provider regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record. I will not hold Focus Therapy, or counselors liable for any misinterpretation of the information in my medical record as a result of not having consulted my care provider for the correct interpretation. I understand that I am not required in any way to sign this release. This authorization is subject to a written revocation at any time except in those circumstances in which the counseling center has taken certain actions in reliance on such authorization. However, this authorization shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. This authorization will automatically expire 12 months from the end of involvement in our programs or as specified in the revocation below.

_____ _____ _____ _____
Signature Date Witness Date

Relationship to Student

☐ If student is a minor or incapable of signing, a copy of the appropriate legal documentation is attached if applicable. If I have joint custody, I have discussed this matter with the other legal guardian(s).

☐ **DRIVERS LICENSE/IDENTIFICATION VERIFIED**

REVOCATION (optional) – This authorization is revoked for the following specified dates, events, or conditions.
Date:_____Event:_____ Condition:_____