Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

I understand that under Nebraska's law requires each client's consent for the release of confidential information related to mental health or developmental disability. With this understanding, I hereby waive any right to confidentiality arising under Nebraska's law and authorize the release of records of information, but only the extent specified below.

I authorize Janette Stallings, APRN and _____ to release and/or receive the following information concerning myself or my child:

_____ Diagnostic Evaluation Results

_____ Educational Records

_____ Progress Notes

_____Treatment Plan

_____ Treatment Summary

_____ Discharge Reports

_____Any and All Records

_____ Other _____

Patient Signature:_____ Date: _____

Guardian Name/ Signature:_____ Date: _____