Omaha OB/GYN Associates, P.C.

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Authorization of Disclosure of Mental Health Treatment Information

I, _____ (Name), whose date of birth is _____, and is working with

therapist:_____, authorize Omaha OB/GYN Associates to disclose and/or obtain information from:

Person/Organization: _____

Address: _____

Phone: _____ Fax: _____

Specific information to disclose as follows:

○ Initial evaluation ○ Psychological evaluation ○ Psychiatric evaluation ○ Substance use related diagnosis and treatment ○ Treatment plan ○ Progress report ○ Progress notes ○ Treatment/Discharge summary	○ Presence/Participation in treatment ○ Medication management information ○ Educational information ○ Medical/Health ○ HIV/AIDS status ○ Legal history ○ Other:_____ ○ Other:_____

The reason for this disclosure is to coordinate collaboration of services. Specify any other reason for disclosure:
_____

I am authorizing the disclosure of confidential information that is to be used in conjunction with the professional services I am receiving. I understand that no services will be denied to me solely because I refuse to consent to the disclosure of information. I understand that I am not required in any way to sign this disclosure. I understand that I am able to receive a copy of the disclosure upon request; a copy of this authorization is as good as the original.

This consent is subject to revocation at any time except to the extent that action has already been taken on it. I understand that this authorization shall remain in effect until withdrawn or cancelled by me ***in writing*** or until DATE_____ (no more than 90 days if one time disclosure or not more than 12 months if ongoing disclosure)

I understand that the records released may include drug and alcohol related information that is protected by federal confidentiality regulations. Those regulations also prohibit further disclosure of such information without my specific consent.

_____ _____ _____
Print Legal Name **Sign Legal Name** **Date**

_____ _____ _____
Witnessed by **Parent/Guardian Signature** **Date**

Relationship to patient/client (circle one): € *Self* € *Parent* € *Legal Guardian*