Councill Psychiatric Care Specialists, LLC

Release of Information Form

919 Galvin Road South Suite A Bellevue, NE 68005
Phone: 402-881-0678 Secure Fax: 402-625-0664

Patient Name: ____________________________ Date of Birth: _____/______/_____
Address: ________________________________ City: __________ State: ______ Zip: _____________
Email Address: ___________________________________ Phone: __________________

I authorize and direct Councill Psychiatric Care Specialists, LLC to (check boxes below):

☐ Release information to: Name and Title: __________________________________
Organization: __________________________________
☐ Receive information from: Address: __________________________________
Phone: __________________________________
Fax: __________________________________
E-mail: __________________________________

Covering the Period of Care from: ______________________ to _________________________

Or all past, present, and future encounters/visits : ☐ Yes ☐ No

State and Federal law protect the following information. I authorize the following PHI to be released from my medical record (Indicate dates where appropriate when only certain periods of treatment should be disclosed):

HPI (History and Physical):	☐ **Yes**	☐ **No**	**Dates: _____________________**
Psychotherapy Records:	☐ **Yes**	☐ **No**	**Dates: _____________________**
Alcohol/Drug Substance Abuse Records:	☐ **Yes**	☐ **No**	**Dates: _____________________**
Medication Efficacy Follow up Appointments:	☐ **Yes**	☐ **No**	**Dates: _____________________**
Laboratory Reports	☐ **Yes**	☐ **No**	**Dates: _____________________**
Other:	☐ **Yes**	☐ **No**	**Dates: _____________________**

The purpose(s) of requesting the information is (check all that apply):
☐ **Legal** ☐**Insurance**
☐ **Personal continuation of care** ☐**Other ____________________________________**

Your indicated records will be disclosed through secure (encrypted) electronic fax or email unless another method is indicated: below:
☐ **Paper Format** ☐ **Fax (to healthcare provider only)** ☐**U.S. Mail**

By Signing this authorization form, I understand that:

- **Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.**
- **I have the right to revoke this authorization at any time: Notice of Revocation must be made in writing and presented to mailed to Councill Psychiatric Care Specialists LLC. (919 Galvin RD. S. STE. A, Bellevue, NE, 68005).**
  Revocation will not apply to information already disclosed in response to this authorization.
- **Unless otherwise revoked this authorization will expire one calendar year from the date signed.**
- **Treatment records needed for payment from insurance, insurance enrollment or eligibility for insurance benefits is not conditioned on whether or not I sign this form.**
- **Any disclosure of information carries with it the potential for re-disclosure, and the information may not be protected by federal confidentiality rules.**

Signed: ____________________________ Printed Name: _______________________ Date: ________________

Signature of Guardian (if patient is a minor) or Power of Attorney (POA):
Signed: ____________________________ Printed Name: _______________________ Date: ________________
Relationship: _______________________