Authorization for Release of Information
Behavioral Health Solutions, PC
917 Wildwood Lane Ste 153, Nebraska City, NE 68410
(402) 216-0561
www.bhsne.com

Permit for the release of information regarding: ____

I authorize and request the exchange of information between the two parties identified below:

Name | Agency | Phone Number

Name | Agency | Phone Number

I understand that this exchange of information is solely for the purpose of behavioral health treatment. I understand that pertinent information may include medical records, psychiatric records, psychological testing and results, therapy notes, educational records, speech and language pathology records, occupational therapy reports, and other information which will assist in the delivery of behavioral health treatment.

Furthermore, I understand that the information exchanged will be treated as confidential information and will not be released to any other parties without the express written permission of the patient of the patient's legal representative.

Signature of patient or legal guardian | Date

Signature of Witness | Date

This agreement will expire 6 months of the date signed.