Hill Counseling and Consulting, P.C.
11071 West Maple Road
Omaha, NE 68164
Office: 402-871-9979
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hillcounselingandconsulting.com

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____ DOB: _____

I request and authorize _____

To release and receive healthcare information of the patient named above to:

Name: HILL COUNSELING AND CONSULTING, P.C.

Address: 11071 West Maple Road City: Omaha State: NE Zip Code: 68164

This request and authorization applies to:

❑Psychological History/Treatment Summary
❑Alcohol/Drug Use Summary
❑Assessment/Evaluation Reports
❑Discharge Summary
❑Attendance/Compliance Information
❑Family History and Social Information
❑Progress Notes
❑Treatment Plans
❑Other_____

Purpose of Release:

❑Continuity of Treatment
❑Coordination of Care
❑Contact with Referral Source
❑Alcohol/Drug Treatment Facilitation
❑Case Management
❑Assessment/Evaluation
❑Follow-up
❑Family Involvement/Support

☐ Other: _____

As the person signing this consent, I understand that I am giving my permission to the above-named person/agency for disclosure of protected health information as defined under the Health Insurance Portability and Accountability Act (HIPAA). I understand that once my protected health information is used/disclosed pursuant to this authorization, the information may no longer be protected by the privacy regulations and may be subject to re-disclosure by the recipient(s). I understand that I have the right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that I have authorized the use and/or disclosure of my health information and such use and/or disclosure has already occurred. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. Persons/agencies who request information under this release may use a copy or facsimile of this form in place of the original signed authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Hill Counseling and Consulting, PC.

This authorization will automatically expire (1) year from the date I sign, unless otherwise revoked or an earlier date is specified _____. (Date not to exceed (1) year)

By signing this form, I acknowledge that I have read and understand this Authorization and had a chance to ask questions and receive adequate answers about the disclosure of the health information. I authorize the use/disclosure of my health information in the manner described above. Additionally, I have been provided a copy of this form.

Patient Signature: _____ Date Signed: _____

If client is under 19 years of age the Parent/Legal Guardian must sign.

Parent/Legal Guardian Signature _____ Date Signed: _____

Relationship to Client: _____

I hereby revoke my authorization and consent for release of information to the person, facility listed. _____ Revocation: Signature and Date _____