

CONSENT TO RELEASE OF INFORMATION

MICHAEL BURKE, PSY.D. & ASSOC., P.C.

3720 Ave A, Suite E

Kearney, NE 68845

Phone: (308)234-5644 Fax: (308)234-5652

Patient's Legal Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

By signing this form, I am allowing Michael Burke, Psy.D. & Assoc., P.C. to \_\_\_ release or \_\_\_ obtain written and oral information by telephone, fax, electronic data exchange, or mail concerning the above named patient with the following individual or agency:

\_\_\_\_\_  
Name of Person and/or Institution

\_\_\_\_\_  
Address City State Zip

( ) ( )  
Phone # Fax #

Check the information to be disclosed:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Psychiatric Evaluation           | <input type="checkbox"/> Verbal Information            | <input type="checkbox"/> Medical Records     |
| <input type="checkbox"/> Progress Notes                   | <input type="checkbox"/> Laboratory Results            | <input type="checkbox"/> Annual Review       |
| <input type="checkbox"/> Psychological Testing/Assessment | <input type="checkbox"/> Billing Info                  | <input type="checkbox"/> Initial Assessments |
| <input type="checkbox"/> Educational/Vocational Records   | <input type="checkbox"/> Appointment Dates/Info        | <input type="checkbox"/> Therapeutic Summary |
| <input type="checkbox"/> Service Plan/ICP/Treatment Plan  | <input type="checkbox"/> Social History                | <input type="checkbox"/> Discharge Summary   |
| <input type="checkbox"/> All of the above                 | <input type="checkbox"/> Other: (Please specify) _____ |  |

Please indicate the reason for release:

- |   |  |                                |                              |  |
|---|--|--------------------------------|------------------------------|--|
| <input type="checkbox"/> Continuity of Care             | <input type="checkbox"/> Rehab/Disability              | <input type="checkbox"/> Legal | <input type="checkbox"/> PCP | <input type="checkbox"/> Transferring Care |
| <input type="checkbox"/> Medication Management Provider | <input type="checkbox"/> Other: (Please specify) _____ |                                |                              |  |

This authorization is voluntary. If I choose to cancel this consent at a later date, I must send written notification to: Michael Burke, Psy.D. & Associates, P.C., 3720 Ave A, Suite E, Kearney, NE 68847. If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would NOT be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release the information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Medical Records at the above address.

Confidentiality of the information is protected by HIPAA. Further disclosure is prohibited without specific consent from whom it pertains. General authorization is not sufficient for this purpose.

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND FEDERAL LAW**

I understand that the information to be released may include information in the following categories unless I specifically deny the release (initial any category not to be released).

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Mental Health | <input type="checkbox"/> HIV-related information |
|--|--|--|

This agreement will expire one year from the date of this signature, or on date specified: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_  
Legal Guardian Signature Date

\_\_\_\_\_  
Witness signature Date

Only clients 19 years of age or older, legal representative, can authorize release of mental health information.

Only clients, regardless of age, can authorize release of substance abuse information.

Office use only:

Please send records: \_\_\_\_\_ Date records/request was sent and by whom: \_\_\_\_\_  
Please request records: \_\_\_\_\_ Description of records sent: \_\_\_\_\_