# 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:**

___ Psychiatric Evaluation
___ Progress Notes
___ Psychological Testing/Assessment
___ Educational/Vocational Records
___ Service Plan/ICP/Treatment Plan
___ All of the above

___ Verbal Information
___ Laboratory Results
___ Billing Info
___ Appointment Dates/Info
___ Social History
___ Other: (Please specify) _____

___ Medical Records
___ Annual Review
___ Initial Assessments
___ Therapeutic Summary
___ Discharge Summary

**Please indicate the reason for release:**

___ Continuity of Care ___ Rehab/Disability ___ Legal ___ PCP ___ Transferring Care
___ Medication Management Provider ___ 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 INFOMRATION 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).

___ Substance Abuse ___ Mental Health ___ 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: _____
Please request records: _____

Date records/request was sent and by whom: _____
Description of records sent: _____