ASSOCIATED COUNSELING PROFESSIONALS
2255 South 132nd Street * Suite 200 * Omaha, NE 68144-2573
(402) 334-1122 – Telephone * (402) 334-8171 – Fax * acpcounseling.com

Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Rights

- *You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.*
- *If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.*
- *You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.*
- *You have a right to a copy of this signed Authorization.*
- *If you choose not to agree with this request, your benefits or services will not be affected.*

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and State laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in One (1) year from the date of my signature below unless otherwise stated herein.**

_____ Disclose Information To AND/OR _____ Disclose Information From

_____ is authorized to release or receive protected health information related to the evaluation
(Provider You Want to Release Your Information To/From - Please Print {**NOT YOUR ACP PROVIDER**}

and treatment of _____ _____ _____ /_____ /_____
(Client Name) (Client Social Security #) (Date of Birth – MM/DD/YYYY)
Telephone Number _____ Fax Number _____

ACP Provider Name: _____ ACP Provider Phone: (402) 334-1122 – FAX (402) 334-8171

ACP Provider Address: 2255 South 132nd Street, Suite 200 * Omaha, NE 68144-2573

Disclosure may include, but not limited to, the following verbal or written information:

_____ MY ENTIRE RECORD

OR, SPECIFY _____
_____
_____
_____.

_____
(Signature Patient, Parent, Guardian or Authorized Representative) (Date)

_____
(Signature of Witness) (Date)

NOTE: ACP is requesting medical information, but in doing so is NOT authorizing to be charged/billed for this service. Please contact ACP if any costs are attached to this request, prior to sending any material. Thank you.