RIVER CAIRN COUNSELING

Mental Health Treatment Release of Information

I, _____ [Client name], whose Date of Birth is _____,

authorize River Cairn Counseling to ☐ disclose to and/or ☐ obtain from:

_____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed
(Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Nursing/Medical Information
_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes*
_____ Other_____
_____ Other_____

(*Cannot be combined with any other disclosure)

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to River Cairn Counseling at 5539 S. 27, Suite 104, Lincoln, NE 68512. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date (No more than 1 year from today's date): _____ or as otherwise indicated: _____
_____