Insight
Counseling and Recovery, LLC

2908 W 39th Street, Suite B – Kearney, NE 68845 – Phone: (308) 237-0391 – Fax: (308) 708-7452

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Insight Counseling and Recovery, LLC. Is authorized to release information regarding the following client to the individual or facility listed below:

Client Information:		Releasing information to the following individual or facility:	
Name:		Name:	
Guardian:	*(If applicable)*	Relationship:	
		Office or Facility:	
DOB:		Location:	
Phone:		Phone:	

As the client or legal guardian, I acknowledge that this release also authorizes disclosure of protected health information from _____ to Insight Counseling and Recovery, LLC regarding _____.

As the client or legal guardian, I also acknowledged the purpose of disclosure is to assist with evaluation and treatment, in addition to financial aspects for the services rendered.

The information to be released:
___ Social History ___ Treatment ___ Medical History ___ Educational records ___ Diagnosis

___ Substance Use History ___ Test Results ___ Other (specify) _____

X _____ X _____ _____
Signature of Client / Legal Guardian Printed Name Date

X _____ _____
Signature of Witness Date

I understand that all client information is confidential and cannot be disclosed without my written consent unless otherwise provided for in state of federal law. I understand that I may revoke this authorization at any time, except to the extent that measures have already been taken to comply with it.

Re-Disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also know as HIPPA) and the recipient of your health information may potentially re-disclose it. I understand that my records may include related drug and alcohol abuse information, which is protected under Federal Confidentiality Regulations (42 CFR, Part 2). I understand that by signing this form I authorize the release of that information to the requesting party. Disclosure of my records to any person other than that person or organization outlined above is prohibited without my specific consent.

Without my expressed revocation, this authorization will automatically expire 12 months from date signed or 90 days from the date of discharge.