MidWest BEHAVIORAL HEALTH
1530 S 70th Street, Suite 200
Lincoln, Nebraska 68506
Phone: 402.327.0073
Fax: 402.327.0204

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Client Name:____ DOB:____________________

I hereby authorize my MidWest Neurofeedback provider: ☐ Kara J. Antoniak, APRN ☐ Susan E. Gripp, DNP
☐ Julie M. Maikranz, PhD ☐ Tim R. Riley, PhD ☐ Aaron C. Stratman, PhD ☐ George E. Williams, PhD
☐ ________________________________

to provide and/or receive the specified information from the following person or organization:

Name of person or organization information is to be **requested from and/or sent to**:

____

Address/City/State/Zip:

____

Phone/Fax:

____

For the following purpose(s):

☐ Continuing treatment ☐ Planning and coordination ☐ Case management ☐ At the request of the client
☐ Other:____

The following information, including identified Protected Health Information is subject to this authorization:

☐ Discharge summary
☐ Therapy records/progress notes
☐ Education or Special Education records
☐ Medical history and evaluation(s)
☐ Therapy history or summary
☐ Psychological/drug and alcohol evaluations
☐ Standardized test results
☐ Neuropsychological report
☐ Other:____

This authorization will remain in effect for: ☐ one year from the date signed below, or ☐ until: ________________ (whichever is sooner) and may be received or released in written form, verbally, via telephone, fax, email or other electronic means or any other medium agreeable to both parties.

My signature below indicates I have read and understood this document. I understand I may revoke this authorization at any time by sending written notice to the person/facility releasing records. Such revocation is not valid if 1) action was taken previously in reliance on this authorization or 2) this authorization was obtained as a condition for obtaining insurance coverage. I understand information released may include reports relating to mental or behavioral health and substance use. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect by ability to obtain treatment, receive payment or my eligibility for benefits.

I understand and agree that this form may be duplicated for the purpose of requesting records. Copies or faxes of this release are to be accepted as the same as the original document. Confidentiality of this information is protected by federal law and no further disclosure is permitted without written consent of the undersigned.

______________________________________ ____________________
Signature of Client Date Signed

______________________________________ ____________________
Signature of Parent or Legal Guardian Relationship to Client