Lincoln Behavioral Health Clinic

Authorization to use and disclose protected health information

Client Name_____ Birthdate_____
Authorizes Lincoln Behavioral Health Clinic, Inc. to
_____Provide Information to and/or _____ Receive Information from

NAME_____
BUSINESS_____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE NUMBER _____

Information to be released:

_____Medical records, inpatient and outpatient treatment of physical disorder
_____ Psychiatric records, inpatient and outpatient treatment, of psychological disorder
_____ Substance abuse treatment, inpatient and outpatient, of substance abuse disorder
_____ Bio-psychosocial History, including educational and vocational records
_____ Psychiatric and psychological Evaluations
_____Academic and educational records
_____Treatment Plan
_____ Discharge Summary
_____Other (specify) _____

For the purpose of _____
This consent form is valid for one year from the date of signature, or as specified, _____but can be revoked with a written request. I release Lincoln Behavioral Health Clinic, Inc. from all liability that may result from the release of the information requested.

_____ _____
Signature of Client/Parent/Guardian Date

_____ _____
Signature of Professional (or other witness) Date

Please send records to ATT: _____
Lincoln Behavioral Health Clinic
3201 Pioneers Blvd, Suite 202
Lincoln, NE 68502
(402) 489-9959 FACSIMILE (402) 489-2219

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my behavioral health provider generally may not deny behavioral health services if I deny consent and signature of this authorization unless such services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.