Mental Health Alliance

815 Flack Ave, Alliance NE 69301 Phone: 308-762-2723 Fax: 308-217--4277 Authorization to Release Protected Health Information 72 Hours Advance Notice is needed to process your request. There may be a fee for this service. Request Records TO: Request Records FROM: Mental Health Alliance Mental Health Alliance Provider: _____ ☐ Provider: _____ 815 Flack Alliance NE, 69301 815 Flack Alliance NE, 69301 PH: 308-762-2723 Fax: 308-217-4277 PH: 308-762-2723 Fax: 308-217-4277 Other Other Name:_____ Name:_____ Address: Address:_____ Phone:_____ Phone:_____ Fax:_____ Medical Records Of: Patient Name:_____ Last First Date of Birth:_____ Phone Number:_____ Address: ZIP State City Street or PO Box Dates Of Service: From: _____ Information to be Released: □ Radiology Reports □ Vocational testing results □ Academic testing Results □ Emergency Room Report ☐ Entire Record □ Medical Records ☐ Psychological test results □ Medication Lists Other____ □ Personality profiles □ Behavior programs □ Medication Checks ☐ Therapy progress reports □ Treatment Plan History and Physical □ Safety Plan □ Summary Reports □ Discharge Summary □ Labs □ Intelligence testing results ☐ Social History The Above information will be used for the following purposes: □ Other_____ Disability determination □ Coordination of Care □ Attorney/Legal ☐ Treatment placement

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this at any time by providing written notice, and this consent automatically expires after one year or on completion of treatment. I have been informed what information will be given, it purpose, and who will receive the information. Information is protected by Federal confidentiality rules (42 FR Part2). This is a reciprocal release permitting exchange of written purpose, and who will receive the information. Information is protected by Federal confidentiality rules (42 FR part2). This is a reciprocal release permitting exchange of written purpose, and who will receive the information. A reproduction of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

| writing. | | | |
|-----------------------|-----------------------------|------------|-----------------|
| SIGNED: | | DATE | |
| | | DATE | |
| Witness: | | DATE | |
| REVOKED: | | - One Vear | □ One Time only |
| EXPIRATION: 90 Days | ☐ Termination from services | Une real | |