CONCORDIA UNIVERSITY
NEBRASKA

RELEASE OF INFORMATION

I, _____ _____, hereby authorize
(name of individual) (date of birth)

_____ and _____
(name) (name)

_____ and _____
(organization) (organization)

_____ and _____
(address) (address)

To exchange the following information:

___ Medical History and Physical Findings
___ Family & Social History
___ Treatment Plan
___ Discharge Summary
___ Psychological Information/Testing
___ Progress in Treatment
___ Other: _____

The information is needed for the following purpose:

TO EFFECT A CONTINUUM OF CARE FOR THE CLIENT'S TREATMENT

I understand that I may revoke, in writing, my consent to allow this information to be released, at any time, except to the extent that action will have taken on information released prior to the revocation of my consent. I understand that my records are protected under State and Federal confidentiality regulations.

OTHERWISE, THIS CONSENT FORM IS VALID UNTIL:

_____
(Statement of date, event, or condition upon which consent will expire without written revocation)

DATE: _____

SIGNATURE: _____
(Client) Parent/Guardian (if required)

WITNESSED BY: _____