Woodhaven Counseling Associates, Inc.
12001 Q Street • Omaha NE 68137
Voice: 402 592-0328 • Fax: 402 592-4170 • Email: wca@woodhavencounseling.com

Authorization for Release of Information

My Name (Client): _____ My Date of Birth: _____

Address: _____

City: _____State: _____Zip:_____

I authorize _____ **to communicate with the following person/organization:**

Name: _____

Address: _____

City: _____State: _____Zip:_____

Phone: _____ Fax: _____

I Authorize the Information Release in order to:
☐Receive Information from WCA, Inc. ☐Provide Information to WCA, Inc. ☐Both Receive and Provide Information

The specific type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- ☐ Complete records
- ☐ Admission or discharge summaries
- ☐ Behavioral assessments and/or progress notes
- ☐ Consultation reports
- ☐ Psychological or psychiatric evaluation(s)
- ☐ Other: _____
  _____
- ☐ Lab results/x-ray reports
- ☐ Communication related to care and treatment
- ☐ History/Physical exam (H&P report)

I understand that the information in my or my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This Release is for the purpose of:

☐ Ongoing communication for treatment provided by Woodhaven Counseling Associates, Inc.

☐ Other_____

I understand that I have a right to revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of WCA, Inc.. If I do this, it will prevent any releases after the date it is received but can not change the fact that some information was sent or shared before that date. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand and agree that this Authorization will be valid and in effect until_____ (or up to one year from date below if not specified) unless I choose to revoke it. I understand that after that date, no more information can be used or released to or from WCA, Inc. unless I sign a new Authorization like this one.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Client Signature of Parent/Guardian/Authorized Legal Representative

_____
Date