LYNN BEIDECK, MA, LIMHP, LADC, LPC
(402) 560-9558 FAX (402) 742-6486

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I Hereby Authorize and Direct That: CLIENT NAME: _____

DATE OF BIRTH: _____

_____Lynn Beideck, MA, LIMHP, LADC, LPC will send information to:

_____

_____

_____

_____Lynn Beideck, MA, LIMHP, LADC, LPC will receive information from: expires:_____

_____

_____

_____

This information is needed for the following purpose: _____

_____

And, such disclosure shall be limited to the following information:

_____Evaluation Report
_____Diagnosis
_____Treatment Plan
_____Discharge Summary
_____Written & Verbal Communication
_____Other (please specify)_____

_____Medical History and Physical
_____Social History
_____Progress Notes
_____Psychological Testing & Evaluation
_____Legal Record

I understand that information may include drug or alcohol use or abuse or psychological care or psychiatric care and that this information will not be released to any other agency, individual, or organization for any other purpose without my written consent except as required by Federal or State Law.

I understand I may revoke this consent at any time by sending written notice to Lynn Beideck, MA, LIMHP, LADC, LPC. If I do so, I know this release cannot apply to any information that had been released before receipt of my written notice. I also agree that a photo static copy of this release is as valid as the original.

If signed by a person other than the client: My relationship to the client and my authority to consent and direct this authorization is as follows: _____

Client Signature: _____ Date _____

Parent of Guardian Signature (if minor)_____ Date _____

Witness Signature: _____ Date _____