Mental Health Alliance

815 Flack Ave, Alliance NE 69301
Phone: 308-225-6572 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 FROM:	Request Records TO:
☐ Mental Health Alliance	☐ Mental Health Alliance
☐ Provider: _____ 815 Flack Alliance NE, 69301 PH: 308-225-6572 Fax: 308-217-4277	☐ Provider: _____ 815 Flack Alliance NE, 69301 PH: 308-225-6572 Fax: 308-217-4277
☐ Other Name:_____ Address:_____ _____ Phone:_____ Fax:_____	☐ Other Name:_____ Address:_____ _____ Phone:_____ Fax:_____

Medical Records Of:

Patient Name:_____
First Last

Date of Birth:_____ Phone Number:_____

Address:

_____
Street or PO Box City State ZIP

Dates Of Service: From: _____ To: _____

Information to be Released:

□ Entire Record	□ Academic testing Results	□ Vocational testing results	□ Radiology Reports
□ Medication Lists	□ Psychological test results	□ Medical Records	□ Emergency Room Report
□ Medication Checks	□ Behavior programs	□ Personality profiles	□ Other_____
□ History and Physical	□ Treatment Plan	□ Therapy progress reports	
□ Discharge Summary	□ Summary Reports	□ Safety Plan	
□ Social History	□ Intelligence testing results	□ Labs	

The Above information will be used for the following purposes:

□ Coordination of Care	□ Disability determination	□ Other_____
□ Treatment placement	□ Attorney/Legal	

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, its 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, verbal, or electronically transferred information. A reproduction of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

SIGNED:_____DATE_____

Witness:_____DATE_____

REVOKED:_____DATE_____

EXPIRATION: □ 90 Days □ Termination from services □ One Year □ One Time only