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Authorization to Release and/or Receive Healthcare Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

I request and authorize Encompass Care, LLC to release and/or receive healthcare information:

Name of Agency/Individual

Address and Phone/Fax

Information requested:

<input type="checkbox"/> Medical history and physical	<input type="checkbox"/> Social History	<input type="checkbox"/> Medication Information	<input type="checkbox"/> Communication
<input type="checkbox"/> Psychological evaluation	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Academic Records	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Psychiatric evaluation	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Hospital Records	<input type="checkbox"/> Lab Reports

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. This authorization is good for one year. I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Encompass Care, LLC from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at Encompass Care, LLC. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original copy.

 Printed name of Patient/Legal Representative

 Signature of Patient/Legal Representative

 Date document signed

 Encompass Care Representative