

# Midwest Encouragement and Counseling Center

220 W. 15<sup>th</sup> Street, Kearney NE 68845  
Phone: 308-236-0500 Fax: 308-237-5225

## CONSENT FOR RELEASE OF INFORMATION

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I do hereby grant permission for Midwest Encouragement and Counseling Center to release information to/receive information from:

\_\_\_\_\_  
Name of Contact/Provider Agency/Practice (if applicable)

\_\_\_\_\_  
Address Ph.#

For the purpose of: (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Treatment                         | <input type="checkbox"/> Medication                               |
| <input type="checkbox"/> Educational Information           | <input type="checkbox"/> Psychiatric/Psychological Records        |
| <input type="checkbox"/> Court Proceedings                 | <input type="checkbox"/> Medical/Physical Information             |
| <input type="checkbox"/> Treatment/Discharge Summaries     | <input type="checkbox"/> Substance Abuse Treatment                |
| <input type="checkbox"/> Social History                    | <input type="checkbox"/> Acknowledgement of Presence in Treatment |
| <input type="checkbox"/> Emergency Contact Information     | <input type="checkbox"/> Coordination of Care                     |
| <input type="checkbox"/> Neuropsychological Testing        |   |
| <input type="checkbox"/> Other (Please be specific): _____ |   |

The authorization for the Release of Information is valid for:

- 30 days     60 days     90 days     180 days     365 days

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in the reliance on this release. If not previously revoked, this consent will terminate at the above noted time frame or six months from the date of discharge. I understand that my records may include drug and/or alcohol abuse information, which is protected under the Federal Confidentiality Regulations (42CFR, Part 2). Any further disclosure of my records other than what is outlined above is prohibited without my specific written consent, or as otherwise permitted by such regulations.

\_\_\_\_\_  
**Client Signature** **Date**

\_\_\_\_\_  
**Parent/Caregiver/Legal Guardian (if applicable)** **Date**

\_\_\_\_\_  
**Witness Signature** **Date**

Federal Law protects the confidential information that has been disclosed to you. Federal regulation (42 CFR part 2) prohibits you from making any further disclosures of the information without the direct consent of the legal guardian, or as otherwise permitted by such regulations.