Embrace Mental Wellness LLC
8031 West Center Road, Suite 307 P:
402-281-6881 F: 402-913-3145
www.nebraskatherapist.com

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Client's Name _____

I hereby authorize and direct that: **Embrace Mental Wellness LLC** will release and receive information to:

Name

Address

Phone # Fax #

The information requested is needed for the following purpose:

Medical: Discharge Summary, History and Physical
Psychological: Evaluation
Social: Social History
Educational Transcripts and Test Results
Substance Abuse/Chemical Dependency Evaluation/Treatment Results
Other *(Please specify)*

_____

_____

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 the action in reliance upon it.

If not previously revoked this consent will terminate 30 days after my termination from treatment upon _____

WARNING: The confidentiality of this information this information is allowed without the person's written consent specifying the release of the information in accord with Federal regulations.

If signed by other than the client:

My relationship to the client and my authority to consent and direct this authorization is as follows:

Signed_____
Signature of client or legal guardian Date

Witness_____
Signature Date