Heather A. Jackson – Independent Mental Health Practitioner

5561 S. 48th St., Suite 215H ⁞ Lincoln, NE 68516
Phone: (402) 975-2318 ⁞ Fax: (402) 625-0321 ⁞ Email: heather@hjacksonlimhp.com

Authorization to Release and/or Receive Information

Name of Patient: _____ **DOB:** _____

Address: _____

_____

I request and authorize Heather A. Jackson, LIMHP, LPC to release and/or receive information:

_____

Name of Individual/Provider/Agency

_____

Address, Phone/Fax Number, and/or Email Address

Information Requested (please check):

○ Medical History	○ Mental Health/Social History	○ Medication Information	○ Legal Documents
○ Psychological Evaluation	○ Treatment Plan(s)	○ Academic Records	○ Entire Record
○ Psychiatric Evaluation	○ Discharge Summary	○ Hospital Records	○ Open Communication
○ Other (please specify):			

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care, and/or for further medical treatment. This authorization is good for one year from the date signed or for _____ days. 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 the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Heather A. Jackson, LIMHP, LPC 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 Heather A. Jackson, LIMHP, LPC. 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.

_____

Signature of Patient/Legal Representative

_____

Signature of Provider – Heather A. Jackson, LIMHP, LPC

_____

Date Document Signed