Grand Island Mental Health
& Medical Clinic, LLC

Release of Confidential Information

This release of confidential information authorizes Grand Island Mental Health & Medical Clinic, LLC to send and/or receive information on behalf of:

Patient Name: _____ Date of Birth: _____/_____/_____

Name of Institution*: _____

**Institution-The name of the company/person that you are authorizing to receive or communicate information, NOT Grand Island Mental Health.*

Institution Address:_____
Street *City* *State* *Zip*

Institution Phone Number: (_____)_____-_____

Would you like all information released FROM Grand Island Mental Health? Yes / No

If no, what specific information would you like released? (ex: discharge summary, medications, alcohol/drug assessment, intake assessment, physiological evaluation, clinical notes, recommendations, referral information, verbal information): _____
_____
_____

Would you like all information released TO Grand Island Mental Health? Yes / No

If no, what specific information would you like released? (ex: discharge summary, medications, alcohol/drug assessment, intake assessment, physiological evaluation, clinical notes, recommendations, referral information, verbal information): _____
_____
_____

The purpose of exchanging information is:
___ Coordination of Services

___ Other: _____

This consent is active for the duration of treatment or until terminated by the client.

_____ _____/_____/_____
Signature of Patient/Guardian Date

Notice Disclosure

This information has been disclosed to you from the records whose confidentiality is protected by Federal Law. Federal regulations (42 CRF Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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