Consent to Release Information

Client ___________________________________ Also known as ___________________________

Address ____

Date of birth ___________________________ Telephone ________________________________

I hereby authorize Gina Furr, PhD, 3201 Pioneers Blvd, Suite 218, Lincoln, NE 68502

To release information to: ____

____

To obtain information from: ____

____

This authorization specifically includes the release of information relating to:

_____ yes _____ no Mental Health and Psychological Testing
_____ yes _____ no Substance Abuse (Alcohol/Drug Abuse)
_____ yes _____ no HIV/AIDS Related Information and Testing
_____ yes _____ no Medical Information and Testing
_____ yes _____ no Case Management/Social Service Information
_____ yes _____ no School Information and Testing

Please note any other desired terms of release: ____

____

UNLESS REVOKED IN WRITING WITH A DATED SIGNED REQUEST, THIS AUTHORIZATION SHALL REMAIN IN EFFECT NO LONGER THAN ONE YEAR FROM THE DATE OF SIGNATURE. A PHOTOCOPY OF THIS RELEASE SHALL BE AS VALID AS THE ORIGINAL.

X____ X__________________________

Client/POA Signature Date

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Lincoln NE 68502

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