COGNITIVE BEHAVIORIAL THERAPY ASSOCIATES

108 N 49th Street, Suite 210 ◆ Omaha, NE 68132
Phone: (402) 889-2070

Authorization for Release of Information

I, ____________________________ hereby authorize __________________________ to disclose and /or
(patient name)
receive the following protected health information to/from: ______________________________________

Patient's DOB: ______________________________ Address: ______________________________

Patient's SSN: ______________________________ ______________________________

- ☐ Treatment Summary
- ☐ Psychological Evaluation
- ☐ Discharge Summary
- ☐ All available information
- ☐ HIV/Addiction – Federal Law 42 CFR Chapter 1 Part 2
- ☐ Substance Abuse and/or Addition
- ☐ Other: ______________________________

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(Specifically describe the information to be disclosed, including, but not limited to, meaningful descriptions such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Cognitive Behavioral Therapy Associates in the following manner:

____

(Describe how protected health information will be used to carry out treatment, payment, and/or health care operations of Cognitive Behavioral Therapy Associates)

This authorization shall be in force and effect until (date) ___________________________ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to Cognitive Behavioral Therapy Associates, 108 N 49th Street, Suite 217, Omaha, NE 68132. I understand that a revocation is not effective to the extent that Cognitive Behavioral Therapy Associates has relied on the use of disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Cognitive Behavioral Therapy Associates will not condition my treatment, payment enrollment (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________________
Print Name of Patient or Personal Representative	**Description of Personal Representative's Authority**
______________________________	______________________________
Signature of Parent/Guardian *(if under 19 years)*	**Date**