Consent to Release Information

BY SIGNING THIS FORM, YOU PERMIT THE HEALTH CARE PROVIDER IDENTIFIED BELOW TO DISCLOSE YOUR CONFIDENTIAL, PERSONAL HEALTH INFORMATION.

CLIENT: The client whose information may be released is:

NAME: _____DATE OF BIRTH: _____

ADDRESS: _____CITY: _____ STATE: _____

ZIP: _____ PHONE #: _____

PERSONAL HEALTH INFORMATION: I am consenting to disclose the following personal health information (check applicable items).

☐ My entire counseling record ☐ my billing records

☐ Only the following specific records and information: _____

Provider A:
Name: One Life Holistic Health, Nina Wilson, PLMHP, CFLE, CHLC_____

Address: 1406 Ft. Crook Rd, #401, Bellevue, NE 68005_____

Phone: _402-661-9102_____ Fax #: _____

Provider B:
Name: _____

Address: _____

Phone number: _____ Fax #: _____

Please initial the option below that specifies your request to release information:

_____ Option #1: I am consenting to release of information from Provider A to Provider B.

_____ Option #2: I am consenting to the release of information from Provider B to Provider A.

_____ Option #3: I am consenting to the reciprocal release of information between Providers A and B.

EXPIRATION OF CONSENT TO DISCLOSE INFORMATION:

Expiration of consent is 12 months from the signed date unless otherwise stated.

Date: _____ Event: _____

EXPLANATION OF RIGHTS: I understand that:

- **I can revoke this authorization at any time by giving my written revocation to the Disclosing Provider. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this authorization.**
- **The disclosing provider/plan may NOT condition treatment, enrollment in the health plan or eligibility for benefits on whether I sign this Authorization.**
- **I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer protected by state or federal law.**

_____ _____

Signature of Patient or Patient's Personal Representative **Date**