



Allison L. Bitz, PhD, LMHP

Licensed Psychologist  
Licensed Mental Health Practitioner

Affiliate of The Wellness Center

CONSENT TO RELEASE INFORMATION

Client \_\_\_\_\_ Also known as \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_ Telephone \_\_\_\_\_

I hereby authorize Allison L. Bitz, PhD, 1919 S. 40<sup>th</sup> St., Ste 111, Lincoln, NE 68506

To release information to: \_\_\_\_\_

\_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

To obtain information from: \_\_\_\_\_

\_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

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 \_\_\_\_\_  
Signature Date

FOR PROVIDER FACILITY ONLY:

Request sent by: \_\_\_\_\_ Date: \_\_\_\_\_ Request received by: \_\_\_\_\_ Date: \_\_\_\_\_

Information to be released:  
\_\_\_\_\_ Summaries \_\_\_\_\_ Progress Notes \_\_\_\_\_ Test Report \_\_\_\_\_ Other: \_\_\_\_\_

Information Format:  
\_\_\_\_\_ Verbal Report \_\_\_\_\_ Narrative Report \_\_\_\_\_ Photocopies \_\_\_\_\_ Other: \_\_\_\_\_

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_ Sent by: \_\_\_\_\_ Date: \_\_\_\_\_

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