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. 40th 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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Lincoln, NE 68506

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