**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Patient

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Street Address City, State, Zip Birth Date

**Hereby Authorize:**

**Sarah C. King, Ph.D. Phone: 402 413-6537**

**7130 S. 29th St. Ste G Fax: 402 975-2408**

**Lincoln, NE 68516 Email: DrKing@bwcnebraska.com**

\_\_\_\_ To Receive Protected Health Information From: \_\_\_\_ To Release Protected Health Information To:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Health Care Provider/Agency/Plan/Other Phone Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address (Include City, State, Zip Code) Fax Number

I authorize release by: Any Method: \_\_\_\_\_\_\_\_\_\_ Only these methods: Mail:\_\_\_\_\_\_ Fax: \_\_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**INFORMATION TO BE RECEIVED:**

\_\_\_ Entire Record \_\_\_ Social History \_\_\_ Academic Records

\_\_\_ Psychological Evaluation \_\_\_ Treatment Plan \_\_\_ Consultations

\_\_\_ Psychiatric Evaluation \_\_\_ Termination Summary \_\_\_ Hospital Records and Reports

\_\_\_ Laboratory Reports \_\_\_ Prescriptions \_\_\_ Medical History, Examination, Reports

\_\_\_ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF:** (Check applicable categories)

\_\_\_ Evaluation and/or Treatment \_\_\_ Further Medical Care \_\_\_ Legal Investigation or Action \_\_\_Follow up

\_\_\_ Insurance Eligibility/Benefits \_\_\_ Changing Physicians \_\_\_ Educational Planning and Programming \_\_\_ Personal

\_\_\_\_Supervision and/or Consultation \_\_\_ Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **Sarah C. King, Ph.D.**. **Right to Receive Copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: **Sarah C. King, Ph.D.**. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

**Expiration Date:** This authorization is good until the following date(s) or for one year from the date signed.

**I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Sarah C. King, Ph.D. from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy.**

**Signature of Patient or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:** \_\_\_\_\_\_

*(If signed by other than patient, state relationship and authority to do so.)*

**Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:** \_\_\_\_\_\_