Vest Psychiatric Services, LLC
2935 Pine Lake Road, Suite F
Lincoln, NE 68516
Phone: 402-817-0897
Fax: 402-817-0901

Tina Vest, APRN, CNP
Dr. Barb Eckert, Psy. D.
Gerry Merck, LIMHP, LADC

Authorization for Vest Psychiatric Services, LLC to release health information

_____ _____
Name (Last, first, middle initial) Date of Birth

_____ _____ _____ _____
Street address City State ZIP Code

*I hereby authorize **Vest Psychiatric Services, LLC** to release and receive protected health information to/from:*

Name of Organization/Individual: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone Number: _____ Fax Number: _____

INFORMATION TO BE DISCLOSED: (Please initial information you authorize us to receive/disclose)

___ Medical History, Examination, Reports ___ Social History ___ Academic Records ___ Entire Record

___ Psychological/Psychiatric Evaluation ___ Consultations ___ Prescriptions ___Open Communication

___ Hospital Records and Reports ___ Terminations Summary ___ Laboratory Reports ___ Treatment Plan

___ Other (Specify):_____

SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF: (Please initial purpose)

___ Evaluation and/or Treatment ___ Further Medical Care ___ Legal Investigation or Action

___ Follow up ___ Insurance Eligibility/Benefits ___ Changing Physicians

___ Educational Planning and Programming ___ Personal ___Coordination of Care

___ 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 Vest Psychiatric Services, LLC. **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 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: Vest Psychiatric Services, LLC. 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 until termination of care.

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 Vest Psychiatric Services, LLC & it's independent contractors 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: _____

Relationship if other than patient or a minor child:_____Date: _____

Witness_____ Date:_____