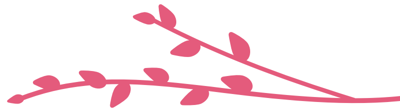

Kelly Brey Love PhD PC
LICENSED PSYCHOLOGIST

7001 A STREET SUITE 100
LINCOLN NE 68510
402.488.6100 (p) | 402.488.6210 (f)

AUTHORIZATION TO RELEASE AND/OR RECEIVE HEALTHCARE INFORMATION

Patient Name: ____ Date of Birth: _________________________

Address: ____ Phone Number: _______________________

I request and authorize Kelly Brey Love PhD PC to ☐ release to and/or ☐ receive healthcare information from:

____ ______________________ _______________________
Name of Agency/Health Care Provider/School/Person Phone Number Fax Number

____
Address (street address, city state and zip)

Information requested and authorized:

☐ Psychological Evaluation	☐ Psychiatric Evaluation	☐ Medical History	☐ Progress Notes	☐ Discharge Summary
☐ Social History	☐ Treatment Plan	☐ Medication Information	☐ Lab Reports	☐ Academic Records
☐ Drug and Alcohol Treatment	☐ Communication	☐ Entire Record	☐	☐

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. The authorization is good for one year from the date signed or for _______ days. I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Kelly Brey Love PhD PC from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing. I further understand that actions already taken based on this authorization prior to revocation will not be affected. A photocopy or fax of this document shall have the same effect as the original copy.

____ ______________________________
Signature of Patient/Legal Representative Date document signed

____
Signature of Witness