



SEND FORM TO:
Think Medical Records Department
7100 West Center Rd, Omaha, NE 68106
T: 531-222-8957 | Fax: 402-506-9093 | medical.records@thinkhealthcare.org

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Reason for Disclosure (required by law)

Please state the reason for this request:

Patient Information

I request access as the Patient Parent Guardian, Representative, or POA (documentation required)

Name of Patient (print clearly)

SSN

Date of Birth

Address

City, State, Zip Code

Contact Phone Number

Manner of Information Requested: (charges may apply)

Paper copy Electronic Transmission

Recipient or Sender Information (select one side or the other)

Table with 2 columns: SEND medical information TO and RECEIVE medical information FROM. Includes fields for Name of Person or Entity to Receive, Street Address, City, State, Zip Code, and Telephone.

By signing below I authorize Think to release all medical information in the way that I have indicated on this form. I understand that I may revoke this authorization at any time in writing, subject to Think's Notice of Privacy Practices. I understand that I can refuse to sign this form and still receive treatment. I understand that Think cannot guarantee the recipient will not inappropriately re-disclose this information. I agree that this authorization will expire one (1) year after the date of signing, or after this date or event.

Signature of Patient or Representative

Date

Name, Relationship (if not the patient)

FOR OFFICE USE ONLY

Date received:

Approved by:

If denied, reason: