**SEND FORM TO:**
Think Medical Records Department
7100 West Center Rd, Omaha, NE 68106
T: 402-506-9000 | 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)***

| SEND medical information TO *(Check ☐ if same as the above)* | RECEIVE medical information FROM *(Only use if sending information to Think ☐)* |
|---|---|
| Name of Person or Entity to *Receive* | Name of Person or Entity to *Receive* |
| Street Address | Street Address |
| City, State, Zip Code | City, State, Zip Code |
| Telephone, Fax or Email, if necessary | 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:**