AUTHORIZATION FOR RELEASE OF INFORMATION

108 N. 49th Street Suite B103 Omaha, NE 68132 402.200.3808

Full Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Email: _____

I, the undersigned, do hereby give my full and free informed consent to authorize the above-named person; firm; physician, clinic, school, hospital, or social agency:

_____ To furnish to Resiliency & Recovery, LLC

_____ To receive from Resiliency & Recovery, LLC

_____ To both furnish to and receive from Resiliency & Recovery, LLC

Or any authorized employee of the same, full and accurate information regarding any medical, psychological, school, or social information including special reports or other pertinent information regarding:

Name: _____ Birth Date: _____

I hereby release the above-named party from any liability for information furnished pursuant to this authorization. This release remains valid for a period of three (3) months after the discharge of the above-named Individual from Resiliency & Recovery Services. Photocopies of this authorization will be considered as valid as the original.

Specific information requested: _____

_____

Purpose of disclosure: _____

_____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR PART 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to who it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

_____ _____

Parent/Guardian/Self Signature **Date**