Meridian Mental Health & TMS Center of Omaha
6910 Pacific Street, Suite 100
Phone 402-504-3707 Fax 402-504-3714
Release of Information

Patient's DOB:_____

Patients SS #:_____

Patient's Address:_____

** ** ** **** ** ** **** ** ** **** ** ** **** ** ** **

I, _____ herby authorize Meridian Mental Health to disclose and/or receive the following protected health information to/from:

Provider Name: _____

Provider Address: _____

Provider Phone Number/Fax Number _____

Please check information you would like released:

- Treatment Summary
- Psychological Evaluations
- Discharge Summary
- Substance Abuse and/or Addiction
- Mental/Behavioral Health
- Other_____
- All of the above

This authorization shall be in effect for one year from the date the authorization was signed.

I understand that I have the right to revoke this authorization in writing, at anytime by sending such written notification to Meridian Mental Health 6910 Pacific St., Suite 100, Omaha NE 68106.

I understand that the information used or disclosed with this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. Meridian Mental Health will not condition my treatment, payment enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization.

Signature_____ **Date**_____