Resilient Psychiatry
Mental Health Services
11422 Miracle Hills Dr. | Suite 401 | Omaha, NE 68154 | Phone & Fax 531.203.5928

Release of Information

I hereby authorize: ____ Risë Mitchell, DNP, APRN, PMHNP-BC of Resilient Psychiatry

To: _____ Release Information To: (indicated below)
_____Obtain Information From: (indicated below)
_____ Exchange Information/Collaborate With: (indicated below)

Name: _____
Business Name and/or Individual Name(s)

Address: _____
Street City State Zip Code

Phone Number: _____ Fax Number: _____

The information requested or authorized for release or exchange pertains to:

_____ Mental Health _____ Legal _____ Sexually transmitted diseases
_____ Education _____ HIV/AIDS _____ Drug and/or alcohol abuse

_____ Other: _____

This authorization is valid for 90 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the provider above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Patient Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date