AUTHORIZATION RELEASE

Joyce Nebgen, MS, BCN, LMHC, LIMHP
Gil Nebgen, Ph.D, PE
Oldmarketneurotherapy.com
joyce@oldmarketneurotherapy.com 402-917-6418 (Gil)
1299 Farman St., Suite #335, Omaha, NE 68102

I,__________________________, hereby authorize **Old Market Neurotherapy** to disclose and/or request
(Client or Legal Representative)

psychological records, medication management and/or other information concerning services rendered to:

____________________________ ________________
Client Name Client's Date of Birth

This information is to be forwarded and/or requested from/to:

____
Agency and/or Name

____
Mailing Address

____
City State Zip

Records are to be forwarded to the ATTENTION OF: ______________________________________

- Disclosure and/or request of information authorized is made for the following purpose:

  ____

- Such disclosure and/or request shall be limited to the following specific types of information:

  ____

- The above authorization is to be in effect until such time as I revoke it in writing or shall terminate on

  ____without express written revocation.
  (Date/Event/Condition)

Client may revoke authorization by completing a "Revocation of Authorization" form.

SIGNED: _________________________ _______________
(Client/Legal Representative) (Date of Signature)

____
(Relationship of Legal Representative)