Lincoln Counseling Enrichment Associates

RELEASE OF INFORMATION

I hereby authorize the staff of **Lincoln Counseling and Enrichment Associates** to release to and/or receive from :

_____

_____

_____

Information relative to my counseling and /or psychological evaluation including:

_____ medical therapy records
_____ physical therapy reports
_____ counseling records
_____ psychological test scores
_____ social history summary
_____ school progress-including academic and behavioral information
_____ Other_____

I understand and agree that this Release of Information shall be valid for three years from the date of the signature unless earlier withdrawn in writing.

I agree that a photocopy of this Release of Information shall be as valid as the original.

I have read this Release, understand its contents and am signing it of my own free will.

_____ _____
Witness Counselee (or parents or guardian if a minor)

_____
Date

7441 "O" Street, Suite 401 Lincoln, NE 68510 (402) 488-8060