TMS INSTITUTE
GREAT PLAINS
MENTAL HEALTH

Direct: (402) 614-0010
Fax: (402) 614-0090

Date of Request: ____________

CLIENT CONSENT TO RELEASE INFORMATION

Client Name:____Date of Birth: __________________

Other Alias:____SSN:______/_____/________

I hereby authorize **the below health care or pharmacy providers** to use or disclose, in verbal and/or written form, the specific information requested below, to TMS Institute of Great Plains Mental Health, LLC and its affiliate management services provider, TMS Institute of America for the purpose of receiving TMS therapy and to obtain prior-authorization for TMS treatment services.

(Doctor Name)__________________________Tele:__________________Fax:________________
(Doctor Name)__________________________Tele:__________________Fax:________________
(Pharmacy)_____________________________Tele:__________________Fax:________________
(Pharmacy)_____________________________Tele:__________________Fax:________________
(Hospital)______________________________Tele:__________________Fax:________________
(Therapist)_____________________________Tele:_Fax:______________ (Other)______________
_____________________Tele:______________ Fax: ___________________ -

One-Way Release:_________ Two-Way Release: _________

Check only the specific information to be used or disclosed:

__X__Treatment Summary
______Psychological Testing
______Psychological Evaluation
__X__Psychiatric History
__X__Substance Use/Abuse History
______School Functioning/Educational
______School Testing/Evaluations
______Medical Information History
__X__Current / Previous Medications
______Hospital Admit Summary
______Hospital Discharge Summary
______Other: _______________________
____

The information is being requested for the following purpose(s):
Transcranial Magnetic Stimulation (TMS therapy)

This authorization shall remain in effect for 60-days from the date of the request.

Continued on the reverse →

Direct: (402) 614-0010
Fax: (402) 614-0090
Toll Free: 1-833-TMS-HELP

Date of Request: _______________

This authorization shall remain in effect 60-days from the date signed below.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I understand that I may revoke this authorization any time before the expiration date (except to the extent that actions have been taken in reliance on it) by submitting a written revocation letter to Great Plains Mental Health Associates.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization
- I hereby release *TMS Institute of Great Plains Mental Health, LLC and TMS Institute of America, LLC from any and all legal responsibility or liability or for any consequences of either:*
  1) having non- stipulated information maintained in confidence or privacy; or
  2) disclosing stipulated information.

Client Signature: ______________________________________ Date: ___________________
(Age 18 and over)

Parent/Guardian Signature:______________________________________Date: ___________________

Witness Name:____Date: ____________________

The witness can attest to the identity of the person(s) signing above, per secure, written, identifying information.

NOTICE TO RECEIVING AGENCY: The patient's record is privileged information, which is protected by various State and Federal laws. Such information may not be disclosed to other persons or entities, including those within the organization wherein the patient is employed, without a separate written authorization from the patient.