Nebraska Authorization for Disclosure of Protected Health Information

Failure to sign this form will not affect treatment or payment, however it may affect enrollment, or eligibility for certain benefits. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me. I also understand that I am not required to disclose my social security number, though disclosure may make it easier or quicker for information to be provided.

Client Name (Last, First, Middle Initial)		Date of Birth
Social Security Number	Case/Chart # (if known)	Period Covered Admission of:

Information will be disclosed to:	**Reason for Disclosure:**
Name:	☐ Eligibility Determination ☐ My Request ☐ Insurance Claim ☐ Legal Purposes ☐ Consultation and/or Treatment ☐ Planning ☐ Other (be specific): _____
Address 1:	
Address 2:	
City, State, Zip:	
The information to be released pursuant to this authorization is limited to records or information from or in the possession or control of the person or organization.	

Specific Information to be Disclosed:

☐ All information that can be disclosed to me relating to the Adult Abuse and Neglect Central Registry and the Child Child Abuse and Neglect Central Registry.

☐ All other non-medical information, records, or documents relating to me which the person or organization could release directly to me.

☐ Entire Medical Record

OR:

☐ Aftercare Referral Form
☐ Discharge Summary
☐ Diagnosis
☐ History & Physical Examination
☐ Laboratory
☐ Medications
☐ Progress Notes
☐ Psychiatric History & Treatment
☐ Psychological Evaluation & Treatment
☐ Social History
☐ X-rays & Other Diagnostic Imaging Results

☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information
☐ HIV/AIDS Information
☐ Sickle Cell Anemia Information

☐ Other (be specific): _____

This Authorization (unless revoked earlier in writing) shall terminate on_____ (must have date or event filled in). By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law, including benefit or enrollment information; or protected health information that may include Drug/Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of indicated information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the then current Notice of Privacy Practices, or by submitting a written request to the health care provider, health care entity, or otherwise (if to anyone else), and it will be honored with the exception of information that has already been released. I also understand if the recipient of the information is not a health plan or health care provider, the information may no longer be protected by privacy laws.

Client's Signature		Date
Authorized Representative's Signature	Authorized Representative's Printed Name	Date

Authorized Representative (Select One): ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Personal Representative

Witness's Signature	Witness's Printed Name	Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (including Federal Regulations, 38 CFR 1.460-1.499, 42 CFR Part 2 and Part 431, Subpart F) which prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. The federal rules restrict the use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65 . A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PLEASE FILL OUT THIS FORM COMPLETELY