

**Authorization for the Disclosure of Protected Health Information**

It has been explained that failure to sign this form will not affect treatment, or payment, **however** it may affect enrollment, or eligibility for certain benefits, provided per Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Client Name (Last, First, M.I.)		Date of Birth
Social Security Number	Case/ Chart Number	Period Covered Admission of:
Information will be disclosed to: (Name, Address, City, State, Zip)		Reason for Disclosure: <input type="checkbox"/> Eligibility Determination <input type="checkbox"/> Request of Subject Individual <input type="checkbox"/> Insurance Claim <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Consultation and/or Treatment Planning <input type="checkbox"/> Other (Please Specify) _____
The information to be released pursuant to this authorization is limited to records/information from or in the possession of the following:  _____		

Specific Information to be disclosed:

- |   |   |
|---|---|
| <input type="checkbox"/> Medications                          | <input type="checkbox"/> History & Physical Examination |
| <input type="checkbox"/> Progress Notes                       | <input type="checkbox"/> Laboratory                     |
| <input type="checkbox"/> Diagnosis                            | <input type="checkbox"/> Discharge Summary              |
| <input type="checkbox"/> Psychiatric History & Treatment      | <input type="checkbox"/> Aftercare Referral Form        |
| <input type="checkbox"/> Psychological Evaluation & Treatment | <input type="checkbox"/> HIV Information                |
| <input type="checkbox"/> Social History                       | <input type="checkbox"/> Other (be specific) _____      |
| <input type="checkbox"/> Drug/Alcohol Information             |   |

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 law and that is applicable to EITHER Drug/Alcohol or HIV related information or BOTH. My signature authorizes release of all such information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the Notice of Privacy Practices the Nebraska Department of Health and Human Services, published April 14, 2003 and it will be honored with the exception of information that has already been released. I also understand that if the person(s)/organizations authorized to receive my PHI is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative ( Parent,  Guardian,  Power of Attorney) \_\_\_\_\_ Date \_\_\_\_\_

Witness's Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE TO RECIPIENT**

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.