Department of Health & Human Services
DHHS
NEBRASKA

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: **1-year from Client signature date**
Information will be disclosed to: (Name, Address, City, State, Zip) **Nebraska Department of Health and Human Services** **Tuberculosis Program,** **301 Centennial Mall South** **Lincoln, NE 68509** The information to be released pursuant to this authorization is limited to records/information from or in the possession of the following:		Reason for Disclosure: ___Eligibility Determination ___Insurance Claim ___Consultation and/or Treatment Planning ___Other (Please Specify)_____

Specific Information to be disclosed:

_____ Medications
_____ Progress Notes
_____ Diagnosis
_____ Psychiatric History & Treatment
_____ Psychological Evaluation & Treatment
_____ Social History
_____ Drug/Alcohol Information
_____ History & Physical Examination
_____ Laboratory
_____ Discharge Summary
_____ Aftercare Referral Form
_____ HIV 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 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 September 23, 2013 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.

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