NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health - Department of Health and Human Services

FORM A: Authorization for Release of Information

Last Name:	First Name:	Middle Initial(s):
Street or Mailing Address:		
Street Address:	State:	Zip Code:

I authorize the release of information regarding my _____ condition to representatives of the Nebraska Department of Health and Human Services, Division of Public Health, Office of Children's Services Licensing for the purpose of determining compliance with licensing regulations and evaluating my fitness to provide care/services in a safe, competent, ethical and professional manner.

Such privileged information shall be released by the following: (One source only. Use additional form for each additional source).

Name of Treating Physician:			
Address:			
City:	State:	Zip Code:	Phone Number:

_____ _____

Signature of Applicant **Date**

Distribution: WHITE COPY - OFFICE OF CHILDREN'S SERVICES LICENSING; CANARY COPY - PROVIDER