Authorization for the Disclosure of Protected Health Information – For The Purpose Of Removal of Firearm Disability

It has been explained that failure to sign this form will not affect treatment or payment. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Subject Name (Last, First, M.I.)		Date of Birth
Social Security Number	Race	
Gender: (circle) Male / Female	County of Legal Residence	Reason for Disclosure: ___ Removal of Firearm Disability (NRRS 69-2409.01)

Information will be disclosed to: (Name, Address, City, State, Zip) (Where should we mail the response):

The information to be released pursuant to this authorization is limited to records/information from or in the possession of the Nebraska Department of Health and Human Services, Division of Behavioral Health or the Nebraska State Patrol and contained in the Nebraska Mental Health Board Clerks Data Base. **Return form to**: Firearms Disability, Division of Behavioral Health, PO Box 95026, Lincoln NE 68509-5026 via US Postal Service or hand delivery. Electronic copies are not permitted.

Specific Information to be disclosed:
The names of the Mental Health Boards the subject individual has been committed by as recorded in the Nebraska Mental Health Board Clerks Data Base.

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This Authorization 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 mental health 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 personal health information 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, ☐ 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.

REV: 1-1-2012 rjb dbh