



Nebraska Department of Health and Human Services
AFFIDAVIT FOR OUTPATIENTS MEDICATION REQUEST FORM
(MH004) MH004

Financial Responsibility
P.O. Box 98936
Lincoln, NE 68509

STATE OF NEBRASKA: COUNTY OF \_\_\_\_\_ ) SS.

The undersigned, being first duly sworn deposes and says that:

The patient's name is \_\_\_\_\_, and patient
is \_\_\_\_\_ years of age, and resides at \_\_\_\_\_; and

The patient has been discharged from Mental Health Board ordered treatment from the facility identified as
\_\_\_\_\_; and

- (a) The patient qualifies as a person who is unable to pay under the same standards of ability to pay set forth in Neb. Rev. Stat., §§ 83-363 to 83-380, and will submit information to the Financial Responsibility Division of the Department of Health and Human Services upon its request, to substantiate that fact;
(b) That prescription medication has been prescribed as necessary for the patient's mental health treatment; and
(c) That the patient's treating physician is

Dr. \_\_\_\_\_
whose address is \_\_\_\_\_

(Signature of Patient or Guardian)

Typed name of Affiant

Subscribed in my presence and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_.

Notary Seal

Notary Public

OFFICE USE ONLY

DHHS/Financial Responsibility \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_
Signature

Center Pharmacist \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_
Signature

White - Financial Responsibility Division

Yellow - Pharmacist

Pink - Patient's Record



**STATE OF NEBRASKA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
FINANCIAL QUESTIONNAIRE (USED FOR DETERMINING ABILITY TO PAY)**

1. NAME		2. AGE	3. MARITAL STATUS	3. SOCIAL SECURITY NUMBER
5. ADDRESS, CITY, STATE, and ZIP CODE		8. COUNTY	7. LENGTH OF TIME AT PRESENT ADDRESS	
5. PREVIOUS ADDRESS		9. COUNTY	10. NO. OF DEPENDENTS	11. MO. RENT OR PYMT
		LEGAL SETTLEMENT COUNTY		\$

12. HAVE YOU EVER RECEIVED TREATMENT IN A STATE OPERATED FACILITY? WHERE?

13. EMPLOYER	14. ADDRESS	15. GROSS MO. INCOME
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**16. OTHER MONTHLY INCOME** **AMOUNT**

INTEREST	DIVIDENDS	ROYALTIES	
\$	\$	\$	\$

PAYING AGENCY AND ADDRESS

RENTAL INCOME	SOCIAL SECURITY	VETERANS	RAILROAD	
\$	\$	\$	\$	\$

ADDRESS OF RENTAL PROPERTY

MISCELLANEOUS INCOME (SPECIFY)

**TOTAL OTHER INCOME** \$

**17. LIABILITIES**

COMPANY	ADDRESS	MO. PYMT.	BALANCE

**TOTAL LIABILITIES**

**18. HEALTH INSURANCE INFORMATION**

COMPANY	ADDRESS	POLICY NUMBER

**19. LIFE INSURANCE INFORMATION**

COMPANY	ADDRESS	AMOUNT	CASH VALUE	POLICY NUMBER

<b>20. ASSETS</b>	<b>AMOUNT</b>
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<b>CHECKING ACCOUNTS</b>		
<b>NAME OF BANK</b>	<b>ADDRESS</b>	

<b>SAVINGS ACCOUNTS</b>		
<b>NAME OF BANK OR SAVINGS COMPANY</b>	<b>ADDRESS</b>	

<b>FARM MACHINERY</b>	
<b>LIVESTOCK</b>	

<b>REAL ESTATE</b>		
<b>HOME</b>	<b>ADDRESS</b>	

<b>MISCELLANEOUS ASSETS (SPECIFY)</b>	
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<b>STOCKS, BONDS, C.D.'s</b>		
<b>AUTOMOBILE MAKE</b>	<b>YEAR</b>	

<b>ACCOUNTS RECEIVABLE</b>	
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**TOTAL ASSETS**

**DID YOU FILE AN INCOME TAX RETURN LAST YEAR?**

<b>22. RELATIVE</b>	
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<b>HUSBAND OR WIFE</b>	<b>ADDRESS</b>	<b>AGE</b>
<b>PARENT</b>	<b>ADDRESS</b>	<b>AGE</b>
<b>GUARDIAN</b>	<b>ADDRESS</b>	<b>AGE</b>

**IMPORTANT:** This form must be completed and returned within 20 days; otherwise, full charges will be assessed on the individual.

**STATE LAW** provides that those electing to disclose financial information along with copies of their most recent income tax return will only be liable to their extent of ability to pay. However, the responsibility of submitting the necessary financial information is the individual's or relative's; and if such financial information is not disclosed, full cost for care and treatment will be assessed.

I certify that the above statements are true and understand that any willful misstatement or misrepresentation will void any agreement and result in the full charge being due and payable.

Date \_\_\_\_\_ Signed \_\_\_\_\_  
(Spouse, Individual or Legal Representative)

Phone or Cell Number \_\_\_\_\_

**Statement of Hospitalization Insurance Coverage**

1. Patient: \_\_\_\_\_ Date Admitted: \_\_\_\_\_
2. Home Address: \_\_\_\_\_
3. Do you have health insurance coverage? \_\_\_\_\_
4. Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
5. Address: \_\_\_\_\_ Phone: \_\_\_\_\_
6. Employer of Insured: \_\_\_\_\_
7. Address: \_\_\_\_\_ Phone: \_\_\_\_\_
8. Name of Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_
9. Address: \_\_\_\_\_
10. Policy Number: \_\_\_\_\_

**Insurance Authorization and Assignment**

Authorization is hereby granted to release such information as may be necessary for the completion of insurance forms for hospitalization and disability claims.

I hereby authorize payment directly to the Lincoln Regional Center of any and all hospital and medical care insurance benefits to which I may be entitled, as a result of service from said hospital. The amount to be paid to said hospital under this assignment shall not exceed the usual charges for such services incurred by me. (A photocopy of this authorization shall be as valid as the original.)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

X  
\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Relationship to Patient

**Patient's HIPAA Privacy Rights.** The patient acknowledges that any protected health information contained in this form is entitled to HIPAA Act of 1996 protections. The patient, as a result, receives Privacy rights such as: limited use and disclosure by State of Nebraska and its business associates; minimum-necessary information access in medical decision making; opportunity for patient to request information withholding and authorization for further disclosure; right to review his/her own medical information (treatment, diagnosis and claims payment) and to make corrections if necessary; and a process to make privacy violation complaints. For more details regarding HIPAA privacy rights, the patient may request a detailed copy of Nebraska's "Notice of Privacy". The signature here demonstrates the patient's awareness to such rights.

Lincoln Regional Center  
PO Box 94949  
Lincoln, NE 68509-4949  
Insurance Department: 402-479-5420

<b>NEBRASKA TAX RETURN COPY REQUEST</b>						<b>FORM 23</b>	
<b>TO: The Nebraska Department of Revenue</b> I hereby certify that I authorize the release of my tax return(s), the information contained therein, and the mailing thereof, for the tax years indicated below, including future tax years, as requested by Nebraska Health & Human Services to determine my ability to pay for services I receive (or will receive) from state institutions or community-based providers, in accordance with Nebraska statutes and administrative codes, chapter 1.							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CLIENT NAME</b>					<b>SSN</b>		
<b>CLIENT SIGNATURE</b> (					<b>DATE</b>		
<b>SPOUSE NAME (Joint Return Only)</b> (					<b>SSN</b>		
<b>SPOUSE SIGNATURE</b> ( ( or AUTHORIZED REPRESENTATIVE SIGNATURE )					<b>DATE</b>		
Authorized representative check one of the following: <input type="checkbox"/> Power of Attorney <input type="checkbox"/> * Court Appointed Guardian <input type="checkbox"/> * Court Appointed Conservator <input type="checkbox"/> Other (Describe) _____							
<b>Authorized Mailing Address for Return:</b>  <div style="text-align: center;">           Lincoln Regional Center            PO Box 94949            Lincoln, NE 68509            Fax# (402) 479-5584         </div> <div style="text-align: center; margin-top: 10px;"> <small>* ATTACH PROOF OF GUARDIANSHIP OR CONSERVATORSHIP</small> </div>							



Lincoln Regional Center  
Financial Responsibility  
PO Box 94949  
Lincoln, NE 68509-4949  
ATTN: Jan Ropers

Internal Revenue Service Center  
PO Box 9941  
Photocopy Unit  
Stop 6734  
Ogden, UT 84409

I would like to request letter 1722 for the tax year listed.

TAX YEAR \_\_\_\_\_

CLIENT NAME \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_  
\_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_

ADDRESS ON MY TAX RETURN \_\_\_\_\_  
\_\_\_\_\_

CLIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Revised 03/2011

# Request for Transcript of Tax Return

▶ Request may be rejected if the form is incomplete or illegible.

**Tip.** Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at [IRS.gov](http://IRS.gov) and click on "Order a Transcript" or call 1-800-908-9946. If you need a copy of your return, use Form 4506, Request for Copy of Tax Return. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)	
4 Previous address shown on the last return filed if different from line 3 (See instructions)	
5 If the transcript or tax information is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax information.	

**Caution.** If the transcript is being mailed to a third party, ensure that you have filled in line 6 and line 9 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.

6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶

- a Return Transcript, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120A, Form 1120H, Form 1120L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . .
- b Account Transcript, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 30 calendar days. . . . .
- c Record of Account, which is a combination of line item information and later adjustments to the account. Available for current year and 3 prior tax years. Most requests will be processed within 30 calendar days . . . . .

7 Verification of Nonfiling, which is proof from the IRS that you did not file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . . . .

8 Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2007, filed in 2008, will not be available from the IRS until 2009. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 45 days . . . . .

**Caution.** If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. Note. For transcripts being sent to a third party, this form must be received within 120 days of signature date.

<b>Sign Here</b>	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

# Request for Copy of Tax Return

▶ Request may be rejected if the form is incomplete or illegible.

**Tip.** You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a Tax Return Transcript for many returns free of charge. The transcript provides most of the line entries from the original tax return and usually contains the information that a third party (such as a mortgage company) requires. See Form 4506-T, Request for Transcript of Tax Return, or you can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Order a Transcript" or call 1-800-908-9946.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (See instructions)	
4 Previous address shown on the last return filed if different from line 3 (See instructions)	
5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.	

**Caution.** If the tax return is being mailed to a third party, ensure that you have filled in line 6 and line 7 before signing. Sign and date the form once you have filled in these lines. Completing these steps helps to protect your privacy.

6 Tax return requested. Form 1040, 1120, 941, etc. and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶

**Note.** If the copies must be certified for court or administrative proceedings, check here

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

\_\_\_\_\_

\_\_\_\_\_

8 Fee. There is a \$57 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.	
a Cost for each return . . . . .	\$ 57.00
b Number of returns requested on line 7 . . . . .	
c Total cost. Multiply line 8a by line 8b . . . . .	\$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer. Note. For tax returns being sent to a third party, this form must be received within 120 days of signature date.

<p>▶ Signature (see instructions)</p> <p>▶ Title (if line 1a above is a corporation, partnership, estate, or trust)</p> <p>▶ Spouse's signature</p>	<p>Date</p> <p>Date</p>	<p>Telephone number of taxpayer on line 1a or 2a</p>
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### Tax Information Authorization

- ▶ Do not sign this form unless all applicable lines have been completed.
- ▶ Do not use this form to request a copy or transcript of your tax return. Instead, use Form 4506 or Form 4506-T.

OMB No. 1545-1105	
For IRS Use Only	
Received by:	
Name	_____
Telephone	_____/_____/_____
Function	_____
Date	____/____/____

**1 Taxpayer information.** Taxpayer(s) must sign and date this form on line 7.

Taxpayer name(s) and address (type or print)	Social security number(s)	Employer identification number
	Daytime telephone number ( )	Plan number (if applicable)

**2 Appointee.** If you wish to name more than one appointee, attach a list to this form.

Name and address	CAF No. _____ Telephone No. _____ Fax No. _____ Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
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**3 Tax matters.** The appointee is authorized to inspect and/or receive confidential tax information in any office of the IRS for the tax matters listed on this line. Do not use Form 8821 to request copies of tax returns.

(a) Type of Tax (Income, Employment, Excise, etc.) or Civil Penalty	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s) (see the instructions for line 3)	(d) Specific Tax Matters (see instr.)

**4 Specific use not recorded on Centralized Authorization File (CAF).** If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions on page 4. If you check this box, skip lines 5 and 6. ▶

- 5 Disclosure of tax information (you must check a box on line 5a or 5b unless the box on line 4 is checked):**
- a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box ▶
- b If you do not want any copies of notices or communications sent to your appointee, check this box ▶

**6 Retention/revocation of tax information authorizations.** This tax information authorization automatically revokes all prior authorizations for the same tax matters you listed on line 3 above unless you checked the box on line 4. If you do not want to revoke a prior tax information authorization, you must attach a copy of any authorizations you want to remain in effect and check this box ▶

To revoke this tax information authorization, see the instructions on page 4.

**7 Signature of taxpayer(s).** If a tax matter applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters/periods on line 3 above.

- ▶ IF NOT SIGNED AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.
- ▶ DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature _____	Date _____	Signature _____	Date _____
Print Name _____	Title (if applicable) _____	Print Name _____	Title (if applicable) _____

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PIN number for electronic signature	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PIN number for electronic signature
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I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(signature and date) (Name of Bank)  
\_\_\_\_\_ to release the following

information to the Lincoln Regional Center, Lincoln, NE and also by a faxed copy:

Amount in any checking account or joint account \_\_\_\_\_.

Amount in any savings account or joint account \_\_\_\_\_.

Amount in any time certificates or joint account \_\_\_\_\_.

Amount in any trust account or joint account \_\_\_\_\_.

Amount in any other assets in the bank or joint account \_\_\_\_\_.

Amount on house loan \_\_\_\_\_.

Amount on car loan \_\_\_\_\_.

Amount on loan \_\_\_\_\_.

Account Number(s) \_\_\_\_\_.

Please return the completed form to the following address:

Lincoln Regional Center  
Financial Responsibility  
PO Box 94949  
Lincoln, NE 68509-4949

Thank you.

<b>(FOR BANK USE ONLY)</b>
Verified By _____
Title _____
Date _____



18618



# Verification of Deposit Medical or Public Assistance Agencies

For faster processing, please complete the form on your computer before printing.

This form is for medical or public assistance agencies requesting consumer deposit information. Please complete the form including the customer authorization signature and fax to the number below. Your completed request will be faxed to the return fax number provided on this form.

TYPE or complete in BLACK INK. Use only CAPITAL LETTERS

Fax Requests To.....1-336-796-8722  
Online Instructions.....www.wellsfargo.com/biz/vod  
Balance Confirmation Services.....1-540-563-7323

## SECTION 1: REQUESTER INFORMATION

L I N C O L N R E G I O N A L C E N T E R

Company Name

F I N A N C I A L R E S P O N S I B I L I T Y

Attention

P O B O X 9 4 9 4 9

Street Address

L I N C O L N

City

N E 6 8 5 0 9

State Zip

Requester Email (optional)

4 0 2 - 4 7 9 - 5 4 2 1

Requester Phone Number

4 0 2 - 4 7 9 - 5 5 8 4

Return Fax Number

## SECTION 2: CUSTOMER INFORMATION

Customer One Full Name (First Middle Last)

Customer Two Full Name (First Middle Last)

Customer One Social Security Number

Customer One Social Security Number

Account Number(s) (Required)

Account Number(s) (Required)

Month / Day / 20 Year

## CUSTOMER AUTHORIZATION

I/We authorize and direct Wells Fargo Bank to release the following information to the above mentioned requestor on my deposit accounts listed above or if only a Social Security Number is provided, all open depository accounts: Account Number, Account Type, Open or Closed, Account Holder(s), Current/Closing Balance, Open/Close Date, Current Interest Rate, Previous Six Average Statement Balances and Previous Six Months Interest Paid. In addition, CDs and IRAs will include: Term, Maturity Date, Interest Payment, Interest Method and Penalty.

Signature of Account Holder Date

Signature of Account Holder Date

Name: \_\_\_\_\_ Client No: \_\_\_\_\_ Adm. Date: \_\_\_\_\_

## United States Citizenship Attestation Form

For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

\_\_\_\_\_ I am a citizen of the United States.

— OR —

\_\_\_\_\_ I am a qualified alien under the federal Immigration and Nationality Act, my Immigration status and alien number are as follows: \_\_\_\_\_, and I agree to provide a copy of my USCIS documentation upon request.

**I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.**

**PRINT NAME** \_\_\_\_\_  
(first, middle, last)

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



I, \_\_\_\_\_, hereby authorize the Financial Responsibility  
(Print Name)  
Office at the Lincoln Regional Center to obtain \_\_\_\_\_  
\_\_\_\_\_ or all  
information relating to my financial status from:

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Parents: \_\_\_\_\_  
Guardian: \_\_\_\_\_  
Representative Payee: \_\_\_\_\_  
Other: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Parents: \_\_\_\_\_  
Guardian: \_\_\_\_\_  
Representative Payee: \_\_\_\_\_  
Other: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

\_\_\_\_\_  
(Patient Signature)

Date \_\_\_\_\_

\_\_\_\_\_  
(Staff Witness Signature)

Date \_\_\_\_\_

The "Information Authorization Release" form authorizes the Regional Center to contact the individual's family member(s), guardian or payee to retrieve any extra financial information that the patient may not have or be able to give.

Revised date 03/2011