

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: Male Female Other (circle)	County of Legal Residence	Reason for Disclosure: <input checked="" type="checkbox"/> Removal of Firearm Disability (NRRS 69-2409.01)

Information will be disclosed to: Your Return Address (Name, Address, City, State, Zip) (individual to complete)

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.

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, <http://dhhs.ne.gov/Documents/hipaa-1.pdf> 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 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 which prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65.