I give my consent for _____

to release the confidential information described below regarding_____ _____ to the Nebraska Health & Human Services Division of Developmental Disabilities staff. I also release the person or entity identified above from any liability for releasing the information identified below. I give permission for the following information to be released:

All records and reports relating to the diagnosis/treatment of a developmental disability, mental health and/or a behavioral disorder.

This release is made for the purpose of **determination of eligibility for Division of Developmental Disabilities services/funding.**

This authorization for release of information will remain valid until _____. (Not to exceed one year from the date signed.) This release may be revoked at any time by written notice to Nebraska Health & Human Services Division of Developmental Disabilities.

Recipient should mail or FAX copies of all material requested to:
Division of Developmental Disabilities
NSOB, 3rd floor
PO Box 98947
Lincoln, NE 68509-8947

Or FAX to: Division of Developmental Disabilities 402-742-2309

The recipient will view a photocopy or faxed copy of the original signed consent as the original.

_____ _____
Signature of Person served or Guardian Date

_____
If Guardian, Relationship to Person Served

_____ _____
Witness Date

_____ _____
Witness Date