REGION II HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Region II Human Services:

COMMUNITY SUPPORT PROGRAM, AIDING RECOVERING MOMS PROGRAM, SPECIAL POPULATIONS PROGRAM

110 N. Bailey P.O. Box 1209
North Platte NE 69103
(308) 532-4860
(308) 532-1157 (FAX)

1012 W 3rd Box 818
McCook, NE 69001
(308) 345-2770
(308) 345-2557 (FAX)

401 West 1st
Ogallala NE 69153
(308) 284-6767
(308) 284-3084 (FAX)

740 Court Street
Imperial, NE 69033
(308) 882-4203
(308) 882-3072 (FAX)

I, _____, birthdate _____,
(name of client) (month, day, year)

authorize Region II Human Services to: ☐ disclose protected health information to
☐ receive protected health information from

_____, _____,
(name of institution or individual) (street address)

_____ _____ _____, _____, _____.
(city) (state) (zip) (phone) (fax)

pertaining to my treatment record:

_____ All available relevant information
_____ Admission and Discharge summaries
_____ Psychological Testing Results
_____ Final progress note
_____ Periodic progress reports
_____ Other (please specify)_____

_____ Academic and Educational records
_____ Medications
_____ Substance Abuse Evaluation
_____ Initial Diagnostic Assessment

This information is to be used for the purpose of _____.

The disclosure of your information ☐ will, ☑ will not result in remuneration to Region II.

Form of information exchange – Please ☒: ☐ Verbal, ☐ Written, ☐ Video, ☐ Audio, ☐ Electronic.

I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization disclosing my information. If I do this, it will prevent any disclosures of my information after the date it is received but cannot change the fact that some information may have been disclosed before that date.
I understand that the records may include drug and alcohol abuse information, which is protected under the Federal Confidentiality Regulations. In that event, any further disclosure of my records other than what is outlined above is prohibited without my specific consent.
I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.
I understand that I may inspect and have a copy of the health information described in this authorization.
I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.
I affirm that everything in this form that was not clear to me has been explained, and I believe I now understand all of it.

This authorization is valid at the date of its signing and continues until one year from the date of my last face to face contact with my provider at Region II Human Services. By signing this authorization, I acknowledge that I have received a copy of this form.

_____
Print Client Name Date:

_____
Signature of Client Date:

_____ _____
Signature of Personal Representative Date: Description of personal representative's authority

_____
Signature of Witness Date:

CS. 10.11.2017