

REGION II EMERGENCY SUPPORT PROGRAM

PO Box 1209
North Platte, NE 69101
(308) 532-4860 ext 312
Fax: (308) 532-1157

PO Box 519
Lexington, NE 68850
(308) 324-7200
Fax: (308) 324-5118

24 hour number (877) 269-2079

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:

- | | |
|---|---|
| <input type="checkbox"/> All available relevant information | <input type="checkbox"/> Academic and Educational records |
| <input type="checkbox"/> Admission and Discharge summaries | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Psychological Testing Results | <input type="checkbox"/> Substance Abuse Evaluation |
| <input type="checkbox"/> Final progress note | <input type="checkbox"/> Initial Diagnostic Assessment |
| <input type="checkbox"/> Periodic progress reports | |
| <input type="checkbox"/> Other (please specify) _____ | |

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