REGION II HUMAN SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Youth Care Coordination, Youth Care Special Population Programs of Region II Human Services

Youth Care Coordination
P.O. Box 1209
110 N. Bailey
North Platte, NE 69103
(308) 532-4860, Ext 311
(308) 534-6961 (fax)

Youth Care Coordination
P.O. Box 818
1012 West Third
McCook, NE 69001
(308) 345-2770, Ext 209
(308) 345-2557 (fax)

Youth Care Coordination
P.O. Box 519
307 East 5th Street
Lexington, NE 68850
(308) 324-6754, Ext. 210
(308) 324-5118 (fax)

Youth Care Coordination
401 West 1st Street
Ogallala, NE 69153
(308) 284-6767, Ext. 211
(308) 284-3084 (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
_____ Academic and Educational records
_____ 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 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