Department of Health & Human Services
DHHS
NEBRASKA

State of Nebraska
Pete Ricketts, Governor

Authorization for the Disclosure of Protected Information to Attorneys or Public Officials

Patient Name (Last, First, M.I.)	Date of Birth
Social Security Number	Patient Address
Information will be disclosed to: (Name, Address, City, State, Zip)	Reason for Disclosure: ☒ At the request of subject individual ☐ Other (Please Specify)
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.	

Specific Information to be disclosed (Check all that apply):

☐ Entire Medical Record, including, but not limited to, patient histories, memoranda, notes (except psychotherapy notes), test results (except raw data and items from psychological test protocols), films, records, diagnosis, evaluations, examinations, discharge summaries, aftercare information, billing records, insurance records, records sent by other health care providers, and medications.

☒ All information regarding alcohol/drug treatment, mental health information, and HIV-related information.

☒ All information that can be disclosed to the subject individual relating to the Adult Abuse and Neglect Central Registry and the Child Abuse and Neglect Central Register.

☒ All other non-medical information, records, or documents relating to the subject individual which the Department of Health and Human Services could release directly to the subject individual.

☐ Other (please specify):

This Authorization shall terminate on (must have date or event filled in) or 60 days after the date of signing this release, if no other date is indicated. By signing this authorization, **I acknowledge that the information to be released may include material that is protected by federal or state law and may relate to Drug/Alcohol treatment, mental health, and HIV-related information.** I understand I may revoke this authorization at any time by submitting a written revocation to the Nebraska Department of Health and Human Services and it will be honored with the exception of information that has already been released. I also understand that the Department of Health and Human Services cannot control what the recipient does with the released information and that such information might be redisclosed by a third party. The released information might no longer be protected by federal or state law. I specifically authorize the Nebraska Department of Health and Human Services to discuss the released information with my attorney, or the government official listed above or with members of his or her staff.

It has been explained that failure to sign this form will not affect treatment, payment, enrollment in a health plan, or eligibility for benefits except in limited circumstances. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Patient's Signature Date

Personal Representative (☐ Parent, ☐ Guardian, ☐ Power of Attorney) Date

NOTICE TO RECIPIENT

This information disclosed to you is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.