Nebraska Mental Health Centers

Lincoln Beatrice Fremont

Authorization to Exchange Confidential Information

In accordance with the Federal and State statutory requirements concerning confidentiality of records, I hereby authorize that confidential information be exchanged by NMHC. A separate authorization form should be signed for each person that information is released to – i.e., school systems, community support services, spouses, and parents of patients 19 years and older, or other family members.

Patient Name: ____ Date of Birth: ______________________

☐ Release Information ☐ Request Information
(Please check one or both)

Information To Be Exchanged between: Nebraska Mental Health Centers AND

Name: ____

Address: ____

Phone Number: __________________________________ Fax Number: _____________________________________

What Information About the Individual Will Be Exchanged?

Any applicable behavioral health and/or substance abuse information including diagnosis, treatment plan, prognosis, and medications(s).

The Purpose of the Authorization: (1) To exchange behavioral health evaluation and/or treatment information to the above party to ensure quality and coordination of care OR (2) for the following specific purposes:

____

Expiration Date: **I understand that this consent may be revoked at any time, by requesting a Revocation of Authorization form. This authorization shall expire 1 year from the date of signature, unless revoked prior to the date _____________.**

Important Rights and Other Required Statements You Should Know:

- You can revoke this authorization at any time by writing to the providers named above. If you revoke this authorization it will not apply to the information that has already been exchanged.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by Federal or State privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services. This authorization is completely voluntary.
- You have a right to a copy of this authorization once you have signed it.
- A photocopy or fax of this exchange of information is as good as the original. NMHC will not condition treatment, payment, enrollment, or eligibility for benefits on this authorization. NMHC notifies you of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected by the rule.

Signature of Patient: ____ Date: ________________________
OR
Signature of Responsible Party: _______________________________________ Date: ________________________ (if applicable)

Name of Responsible Party: ______________________________________ Relationship to the Individual: _____________________

NMHC Staff Signature: ____ Date: ________________________

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