

## AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

**(PLEASE PRINT CLEARLY)**

<b>Patient Name</b> <i>(Last, First, M.I.)</i>		<b>Date of Birth</b>
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	
<b>Phone Number</b>	<b>UNL ID / Other ID Number</b>	

<b>I authorize</b> <i>(Provider/Facility Name)</i>		
<b>Phone Number</b>	<b>Fax Number</b>	
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	
To release my mental health information to:	<b>University Health Center</b> <b>Attn: Counseling and Psychological Services</b> <b>1500 U Street</b> <b>Lincoln, NE 68588-0618</b>	<b>Phone: 402-472-7450</b> <b>Fax: 402-472-4593</b>

<b>I authorize the UNIVERSITY HEALTH CENTER to release my mental health information to:</b>		
<b>Name</b> <i>(Person/Organization)</i>		
<b>Phone Number</b>	<b>Fax Number</b>	
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	

Information to be requested/released	Include information relating to	Date(s) of Service
<input type="checkbox"/> Intake <input type="checkbox"/> Progress Notes <input type="checkbox"/> Assessment Intake/Reports <input type="checkbox"/> Attendance Dates <input type="checkbox"/> Closing Summary <input type="checkbox"/> Medication List <input type="checkbox"/> Psychiatric Intake <input type="checkbox"/> Substance Abuse Evaluation <input type="checkbox"/> Other _____	<input type="checkbox"/> HIV testing/infection or AIDS <input type="checkbox"/> Psychiatric care/mental health <input type="checkbox"/> Treatment for alcohol and/or drug abuse	From: _____ To: _____
	<b>Purpose</b>	<b>Method of Disclosure</b>
	<input type="checkbox"/> Mental Health Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Self (fees apply) <input type="checkbox"/> Other _____	<input type="checkbox"/> Fax <input type="checkbox"/> Will pick up <input type="checkbox"/> Mail                        Date: _____ <input type="checkbox"/> Verbal                      Time: _____

This statement of consent can be revoked at any time before disclosure of the information, and expires on \_\_\_\_\_ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual /institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

I understand Nebraska Medicine and its affiliates will not condition evaluation or treatment on whether I sign this authorization.

Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

UNL Provider Approval \_\_\_\_\_ Date \_\_\_\_\_

Representative/Parent Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_