Consent for Release of Confidential Information

Behavioral Health Specialists, Inc.

ALL AGENCY PROGRAMS
1900 Vicki Lane, Norfolk NE 68701 (main office)
Phone #: 402-370-3140
Fax #: 402-370-3373

Client Name: **Date of Birth:**

I, THE UNDERSIGNED CLIENT, HEREBY AUTHORIZE THE ABOVE AGENCY TO: ☐ Release to: ☐ Obtain From:

Person, Company, or Agency: **Phone #:**

Address (Street, City, State, Zip): **Fax #:**

Relationship to client:

The following Information: (via fax, written or verbal communication)

☐ Initial Assessment
☐ Psychological or Psychiatric Evaluation
☐ Alcohol/Drug Evaluation
☐ Progress Notes
☐ Prescriptions/Medications
☐ Academic/Behavioral Reports
☐ Case Consultation
☐ Discharge Summary & Recommendations
☐ Participation Summary/Certificates
☐ Billing & Demographic Information
☐ Other:_____

For the purpose of providing comprehensive treatment through:

☐ Obtaining Appropriate History
☐ Coordination of Services
☐ Involving Significant Others
☐ Other: _____
☐ Notification in Case of an Emergency
☐ Processing Claims and Payment Authorization
☐ To Fulfill Contract Requirements for State of Nebraska Funded Services.

I UNDERSTAND that my records are protected under Federal regulations governing Confidentiality of Patient Records (42 CFR Part 2), and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I understand that these records could contain information about a substance abuse diagnosis or treatment, AIDS, HIV, Hepatitis, or sexually transmitted disease (STD). I also understand that I may revoke this consent at any time, except to the extent those disclosures have previously been made in reliance to it. If not previously revoked, this consent expires automatically as follows:

This Authorization will automatically expire one year from date signed unless otherwise specified below:

☐ Other Date of Expiration_____

I permit a copy of this Consent to be used in place of the original.

_____ _____
Client Signature **Date Signed**

_____ _____
Client's Authorized Agent Signature – If applicable **Relationship**

_____
Witness

PROHIBITION ON REDISCLOSURE: This information may have been disclosed to you from records whose confidentiality is protected by Federal Laws. [42 CFR Part 2] which prohibits you from making any further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.