WEBER BEHAVIORAL HEALTH

942 N 13th, Geneva, NE 68316
100 N Lincoln Ave, Ste F, York, NE 68467
1811 West 2nd, Ste 450, Grand Island, NE 66803
Phone 402-759-3802 Fax 402-374-4211

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name_____ Date of Birth_____

I hereby authorize Weber Behavioral Health to: _____Disclose to _____Obtain from

___ School ___Agency ___Individual Name: _____

Address: _____

City:_____ State:_____

Information to be disclosed:

___Psychiatric Evaluation
___Psychological Evaluation
___Functional Behavioral Assessment
___Consultation Report
___Financial Record
___Individual Education Program (IEP)
___Progress Notes
___Treatment plan
___Discharge Summary
___Verbal Communication
___Multidisciplinary Report
___Behavioral Reports

Purpose for requested information

___Treatment
___Legal Proceedings
___Other (specify)_____
___Insurance/payer
___Personal

I understand that information in my medical record may include information relating to STD (sexually transmitted diseases, AIDS (acquired immune-deficiency syndrome). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke authorization at any time. I understand that a revocation needs to be in writing and will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when they law provides my insurer with the right to contest a claim under my policy. Unless previously revoked this authorization automatically expires twelve (12) months from date of signature. I consider a photocopy of this authorization is as valid as the original.

I understand that authorizing the disclosure of protected health information is voluntary and that I can refuse to sign this authorization. I understand that I may inspect or haver copied the information to be used of disclosed, as provided in CFR 164.524. I understand that information used or disclosed may be subject to redisclosure by the recipient and no longer protected by federal privacy rules.

Signature of client or representative_____ Date _____

Relationship to Client_____ Witness_____