

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 _____

Primary Care Provider/Clinic _____

Address: _____

City: _____ State: _____ Zip code: _____

Information to be disclosed:

- | | |
|---|--|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Treatment plan |
| <input type="checkbox"/> Functional Behavioral Assessment | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> Financial Record | <input type="checkbox"/> Multidisciplinary Team Report |
| <input type="checkbox"/> Individual Education Program (IEP) | <input type="checkbox"/> Behavioral Reports |

Purpose for requested information

- | | |
|--|--|
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Insurance/payer |
| <input type="checkbox"/> Legal Proceedings | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Other (specify) _____ | |

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 have copied the information to be used or 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 _____