**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 \_\_\_Progress Notes

\_\_\_Psychological Evaluation \_\_\_Treatment plan

\_\_\_Functional Behavioral Assessment \_\_\_Discharge Summary

\_\_\_Consultation Report \_\_\_Verbal Communication

\_\_\_Financial Record \_\_\_Multidisciplinary Report

\_\_\_Individual Education Program (IEP) \_\_\_Behavioral Reports

**Purpose for requested information**

\_\_\_Treatment \_\_\_Insurance/payer

\_\_\_Legal Proceedings \_\_\_Personal

\_\_\_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 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_