Behavioral Health Specialists, Inc.

One Year Release of Confidential Information

Location	Address	Phone	Fax
☐ All Agency Programs (includes all programs listed below)			
☐ Outpatient/EAP	900 W. Norfolk Ave. – Suite 200 – Norfolk, NE 68701	402-370-3140	402-370-3373
☐ Intensive Outpatient Program	900 W. Norfolk Ave. – Suite 200 – Norfolk, NE 68701	402-370-3140	402-370-3373
☐ Community Support	600 S. 13th Street – Norfolk, NE 68701	402-379-1490	402-379-2073
☐ Seekers of Serenity	4432 Sunrise Place – Columbus, NE 68601	402-564-9994	402-562-6458
☐ Sunrise Place	923 E. Norfolk Ave. – Norfolk, NE 68701	402-379-0040	402-379-0759
☐ Youth & Family Services	600 S. 13th Street – Norfolk, NE 68701	402-379-0270	402-844-3400

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 Evaluation
- ☐ Alcohol/Drug Evaluation
- ☐ Progress Notes
- ☐ Prescriptions/Medications
- ☐ Other: **fax/phone calls/emails**
- ☐ Academic/Behavioral Reports
- ☐ Case Consultation
- ☐ Discharge Summary and Recommendations
- ☐ Participation Summary/Certificates
- ☐ Billing and Demographic Information

FOR THE PURPOSE OF PROVIDING COMPREHENSIVE TREATMENT THROUGH:

- ☐ Obtaining Appropriate History
- ☐ Coordination of Services
- ☐ Involving Significant Others
- ☐ Other: **fax/phone calls/emails**
- ☐ 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 (1) year from date signed (unless otherwise specified below).

☐ Other Date of Expiration: _____

When you receive care from multiple programs/providers within our agency (i.e., Outpatient, Community Support, Sunrise Place, Seekers of Serenity Place, Youth & Family Services, etc.) all of those providers will have access to your clinical record.

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

Client and Family/Guardian Signatures

Client Signature: _____ Date: _____

Family/Guardian Signature: _____ Date: _____

Relationship: _____

Witness Signature: _____ Date: _____

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