NEBRASKA LICENSEE ASSISTANCE PROGRAM
Authorization to Release Information

I, _____, in order for the Nebraska Licensee Assistance
(Name of NE LAP client)
Program (NE LAP) to have the information and communication necessary to provide my NE LAP services, authorize and request the NE LAP to release to and receive information from (please check all that apply):

_____ NE Professional Health Services Licensing Board_____

_____ NE DHHS, Div. of Public Health, Investigations Unit_____

_____ NE DHHS, Div. of Public Health, Licensure Unit _____

_____ Employer/Human Resources/Supervisor_____

_____ Treatment Provider_____

_____ Concentra (body fluid screen program)_____

_____ Nebraska Attorney General's Office_____

_____ Other_____

Specific information to be provided is to consist of (check appropriate area):

_____ All available information regarding my case, including all alcohol and substance use information.

_____ Re-release of all other providers' alcohol/substance use assessments/evaluations, progress reports and discharge summaries that I have made available to the NE LAP.

_____ Other (please specify) _____

This authorization is effective for twelve months from the date signed, or on _____, as I have requested, to fulfill the purposes of this authorization, unless sooner revoked. Information released according to the authorization may be subject to redisclosure by the recipient and may no longer be protected by privacy regulations. I understand I may revoke this authorization at any time by notifying the NE LAP Coordinator, NE LAP counselor, NE LAP Clinical Manager, or the Corporate Director of the NE LAP of my revocation of this authorization. Release of information will cease upon receipt of my revocation. I understand such revocation will not apply to information that may have been released prior to revocation. The NE LAP cannot condition NE LAP services based on agreement to this authorization to release information.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

_____ _____
Date NE LAP Client Signature

_____ _____
Date Witness Signature