NEBRASKA LICENSEE ASSISTANCE PROGRAM
Authorization to Release Substance Use Disorder/Mental Health Records

1. Patient Name: _____ Date of Birth: _____

   Other names used in treatment: _____ Phone: _____

   How would you like the information sent? ____ Mail ___ Fax ___ Email

2. I authorize the Nebraska Licensee Assistance Program (NE LAP) to ____Release to; or ____Obtain from:

   Nebraska Licensee Assistance Program, Attention _____
   9239 West Center Road, Suite 201
   Omaha, NE 68124
   402-354-8055 (phone)
   402-354-8046 (fax)

   Email address: _____

   Recipient Name: _____ Attention: _____

   Address: _____ Phone: _____

   _____ Fax: _____

   Email address _____

3. Substance Use Disorder/Mental Health records to be disclosed between (date) _____ to (date)_____:

   ___ Substance Use Assessment ___ Emergency Room Record ___ Labs

   ___ Clinical Notes ___ History and Physical ___ Medical/Nursing

   ___ Continuing Care Plan ___ Intake Assessment ___ Psychiatric/Psychological Information

   ___ Discharge Summary ___ Integrated Summary ___ Treatment Plan

   ___ Other: _____

4. Purpose of disclosure: _____

5. This authorization is effective for twelve months from the date signed, or until _____, 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, except to the extent NE LAP has already acted in reliance on this authorization, by notifying the NE LAP Coordinator, NE LAP counselor, NE LAP Clinical Manager, or the Corporate Director of the NE LAP in writing of my revocation of this authorization. Release of information will cease upon receipt of my revocation. The NE LAP cannot condition NE LAP services, including treatment, payment, enrollment or eligibility for benefits based on whether I sign this authorization. The information authorized for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

   I understand that my substance use disorder records are protected under Federal regulations. 42 CFR part 2 prohibits unauthorized disclosure of these records, and these records generally cannot be disclosed without my written consent except as permitted by law.

   _____ _____
   Date NE LAP Client Signature

   _____ _____
   Date Witness Signature