NEBRASKA LICENSEE ASSISTANCE PROGRAM

Authorization to Release Information to Treatment Provider

The Nebraska Department of Health and Human Services, Division of Public Health, Licensure Unit (the Department) regulates the licensure/registration/certification of health care professionals in the state of Nebraska (credential holders). The Department requires the NE LAP to obtain a signed release of information from clients that authorizes full disclosure to the NE LAP information regarding their alcohol or substance use treatment, including non-compliance with treatment and/or aftercare plans. Your treatment provider will be required to notify the NE LAP within three (3) business days of becoming aware of any non-compliance. If you decline to authorize this disclosure, the NE LAP will no longer be able to provide NE LAP services to you.

I, ____, authorize and request the NE LAP to release to
(Name of NE LAP client)
and receive all available information from:

_____ Treatment Provider____

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.

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 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. You may continue with your treatment provider. However, NE LAP services will be discontinued upon your revocation of this required authorization for disclosure to/from your treatment provider since the NE LAP would no longer be able to monitor your compliance with treatment.

____________________________	____
Date	NE LAP Client Authorization Signature
____________________________	____
Date	Witness Signature