Norfolk Family Coalition
123 N 4th Street
Norfolk NE 68701
(402) 640-2409

Norfolk Community Response

Request and Authorization for Release of Confidential Information

I, _____ hereby authorize the **Norfolk Family Coalition** and **the following entities** to communicate with and disclose to one another in verbal, written or facsimile.

Name – Relationship – Address - Phone Number:

I authorize the Norfolk Family Coalition, as a Nebraska Management Information System (NMIS) user agency and it's contracted agents, to disclose my basic identifying information to NMIS and all of the NMIS user agencies. Entering the information into the NMIS database will make the disclosure. Once the disclosure has been made in reliance upon this authorization, the information cannot be retrieved, and all current and future NMIS user agencies are health and human service providers who are permitted by the NMIS to access and enter data in the NMIS database, which allows them to collect, share, and use basic identifying information about service recipients.

I understand that the Agency cannot condition decisions about my treatment, payment, enrollment, or eligibility for benefits or services on whether or not I sign this authorization. A copy of this authorization shall be as valid as the original. I understand that the information disclosed is subject to re-disclosure by the recipient and may no longer be protected by the federal pribacy regulation, 45 CFS 164 Subpart E.

I understand that I do not have to participate in NMIS. I understand that I may revoke this authorization at any time, by doing so in writing to NMIS user agency, Norfolk Family Coalition. A revocation of this authorization will be effective except to the extent the entity disclosing the information has taken action relying on this authorization. This authorization will expire in 180 days from the date I sign it. I understand that revocation or expiration of this authorization will not affect information that has already been entered into the NMIS database in reliance on this authorization.

I also authorize the Agency to disclose basic identifying information about my dependent(s). Name(s) of the Dependent(s) that the Legal Guardian Authorizes to Participate in Community Response:

Household Members – Name(s) – DOB – Relationship – Other Known Alias/Maiden Name:

*If more space is needed, please use the back of this form.

The purpose for such disclosure is: Family assessment and case management for connections to community resources.

This consent allows your information to be shared between the Program Director for the Norfolk Family Coalition and any partnering agencies within the Norfolk Family Coalition of Norfolk that may assist with your treatment.

- I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse 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.
- I understand that disclosure may be made to persons within the criminal justice system which have made participation in this program a condition of the disposition of any criminal proceedings against me or of my parole/probation or other release from custody.
- I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

This authorization will automatically expire six months post discharge unless otherwise specified:

_____

(Specify the alternative date, event, or condition upon which this consent expires)

_____ _____

Client Signature Date Signed

_____

Witness Signature