

Nebraska Health and Human Services Authorization for Release of Information

Last Name	First Name	Middle Initial
Street or Mailing Address		
City		
State	Zip Code	Social Security Number

This information will be released to:
Acentra Health
1650 Summit Lake Dr. Ste 102
Tallahassee, FL 32317
Phone: 833.840.9945
Fax: 844-421-3626

I authorize the release of the following information necessary to determine the appropriateness of my admission to or continued residence in:

(Name of Nursing Facility if Known)

- Medical and Social Information
- Psychiatric Information if I am found to have an indication or diagnosis of Mental Illness (MI).
- Psychological and Developmental Skill Information if I am found to have an indication or diagnosis of Intellectual Disability (ID) or a Related Condition (RC).

This information may be released to the following:

- The nursing facility, for inclusion in the permanent nursing facility record and use in the development of the overall care plan.
- The Nebraska Department of Health and Human Services (DHHS), for review of the medical and social information to issue a determination regarding the level of medical need appropriate for services provided in a nursing facility.
- The DHHS/Contractor for review of the complete set of information and issue a final determination regarding the appropriateness of nursing facility services or other alternative placement.
- The Behavioral Health Region, for review of the medical, social and psychiatric information and to issue a recommendation regarding services appropriate for mental health and other specialized services.
- The Community-Based Developmental Disability Services Provider, for review of the medical, social, psychological and developmental skill information and issue a recommendation regarding services appropriate for intellectual disability/developmental disability and other specialized services.
- Organizations involved in the development of alternative services, and/or in the assessment or placement of persons who require alternative services, including but not limited to state agencies, specialized service agencies and behavioral health and/or developmental disability service providers, if placement in a nursing facility is found to be inappropriate.
- Service providers, for the purposes of assessment, determination and provision of alternative services such as, but not limited to: residential, service coordination, case management, rehabilitation, vocational training, day programs and other necessary supports, if placement in a nursing facility is found to be inappropriate.

For the purpose of complying with the requirements of the Preadmission Screening and Resident Review Process, the above mentioned information may be shared with other professionals, such as your physician or social services staff from an agency familiar with your needs. The above mentioned information will be treated confidentially and released only for the purpose of making a determination regarding the appropriateness of your admission to or continued residence in a nursing facility, or placement into alternative services, if placement in a nursing facility is found to be inappropriate.

I understand the following:

- I have the right to revoke this authorization at any time.
- Signing this release will not limit my access to treatment.
- The released information may no longer be protected once it is sent to a third party.

This release is valid for one year from the date entered below.

Signature of Individual	Date
Signature of Legal Representative	Date
Signature of Witness	Date