



Region 4 Supported Housing Program
 206 W. Monroe Avenue
 Norfolk, NE 68701
 402-370-3100
 402-370-3125 (fax)

Authorization for Release and Exchange of Information

This document serves as formal authorization for Region 4 Behavioral Health System representatives to receive and exchange information with third parties to verify housing assistance eligibility and coordinate services. Information may be exchanged via verbal, written, or electronic communication.

Verification contacts may include, but are not limited to the following:

- Department of Health and Human Services (DHHS)
- Social Security Administration
- Probation/Parole
- Public Housing Agencies
- Potential/Current Landlords
- Utility Companies
- Housing Support Vendors (e.g., Furniture Stores)
- Other Housing Related Businesses
- Behavioral Health Providers of Support Services:
 - Behavioral Health Specialists
 - Heartland Counseling Services
 - Liberty Centre Services
 - Region 4 Professional Partner Program
 - The Well
- Medical Facilities
- Other (*specify*): _____

Specific information disclosed may include, but is not limited to:

- Housing Application & Program Eligibility
- Landlord Contract, Lease, & Tenant Rental History
- Diagnosis & Initial Diagnostic Interview (IDI)
- Psychological & Psychiatric History/Treatment
- Drug/alcohol (SUD) Evaluation & Treatment
- Medical History & Treatment
- Individualized Service Plan (ISP) & Recovery Goals
- Attendance & Participation in Support Services
- Income & Disability Verification
- Criminal History & Court/Probation Orders
- Program History & Discharge Information
- Complete record (excludes Psychotherapy Notes)

This authorization expires when I am discharged from the Region 4 Supported Housing Program or at my written request. I may cancel this authorization at any time by submitting a written request to Region 4 Behavioral Health System. I understand that Region 4 cannot undo information that has already been shared before my request was received.

I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient in accordance with HIPAA regulations. However, any Substance Use Disorder (SUD) records remain protected by 42 CFR Part 2 and cannot be used against me in any court proceedings without my specific written consent or a court order. I understand I have the right to file a complaint with the Regional Administrator or Secretary of the U.S. Department of Health and Human Services if I feel my privacy has been violated. I acknowledge my right to receive a copy of this form.

Consumer Signature

Printed Name

Date

Legal Guardian Signature (if applicable)

Printed Name

Date

Witness Signature

Printed Name

Date