U.S. Senator Deb Fischer
Constituent Services Request Form

Name: _____ ***Date of Birth:*** _____

Address: _____ ***City/State/Zip:*** _____

Telephone (Day): _____ ***Telephone (Evening):*** _____

Social Security Number: _____ ***E-Mail:*** _____

Third Party Proxy Designation (Optional)

Senator Fischer's office does not provide legal advice or legal services, and any information provided should not be relied upon as such. You should contact an attorney if you believe you need legal representation or have a right to seek redress from the U.S. Government. If you would like our office to be able to communicate about your case with a family member, designated representative, or attorney, please provide the third party's contact information:

Name: _____ ***Relationship to Individual:*** _____

Address: _____ ***City/State/Zip:*** _____

Phone: _____ ***E-Mail:*** _____

Please briefly state your request for assistance. Attach copies of any pertinent documents. To encourage better coordination between government offices, have you contacted any other agencies or elected about this issue? If so, please include which ones and when: _____

_____

_____

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Disclosure Authorization

The Privacy Act of 1974 prohibits the government and private entities under contract to administer government programs from revealing information from the personal files of individuals without the express permission of the person involved. I, the undersigned, hereby authorize Senator Deb Fischer and her staff to receive information pertinent to my request for assistance indicated above.

I certify, under penalty of perjury, that 1.) I provided or authorized all of the information in this privacy release and any document submitted with it; 2.) I reviewed and understand all of the information contained in my privacy release and documents with it; and 3.) all of this information is complete, true, and correct.

Applicant (please print): _____ ***Date:*** _____

Applicant Signature (sign in ink): _____

Return Information:

U.S. Senator Deb Fischer, Attn: Todd Crawford
440 N. 8th St., Suite 120
Lincoln, NE 68508

Phone: (402) 441-4600
Fax: (402) 476-8753
E-mail: Todd_Crawford@fischer.senate.gov

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Authorization for Disclosure of Protected Health Information

Failure to sign this form will not affect treatment or payment, however it may affect enrollment, or eligibility for certain benefits provided by the Nebraska Department of Health and Human Services. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me. I also understand that I am not required to disclose my social security number, though disclosure may make it easier or quicker for information to be provided.

Client Name (Last, First, Middle Initial)		Date of Birth
Social Security Number	Case/Chart # (if known)	Period Covered Admission of:

Information will be disclosed to:	**Reason for Disclosure:**
Name: Office of U.S. Senator Deb Fischer	☐ Eligibility Determination ☐ My Request ☐ Insurance Claim ☐ Legal Purposes ☐ Consultation and/or Treatment ☐ Planning ☐ Other (be specific): _____
Address 1: 440 N. 8th St.	
Address 2: Suite 120	
City, State, Zip: Lincoln, NE 68508	
The information to be released pursuant to this authorization is limited to records or information from or in the possession or control of DHHS (or other party, as applicable).	

Specific Information to be Disclosed:

☐ All information that can be disclosed to me relating to the Adult Abuse and Neglect Central Registry and the Child Child Abuse and Neglect Central Registry.

☐ All other non-medical information, records, or documents relating to me which the Department of Health and Human Services could release directly to me.

☐ Entire Medical Record

OR:

☐ Aftercare Referral Form
☐ Discharge Summary
☐ Diagnosis
☐ History & Physical Examination
☐ Laboratory
☐ Medications
☐ Progress Notes
☐ Psychiatric History & Treatment
☐ Psychological Evaluation & Treatment
☐ Social History
☐ X-rays & Other Diagnostic Imaging Results

☐ Alcohol and/or Drug Abuse Treatment
☐ Genetic Testing Information
☐ HIV/AIDS Information
☐ Sickle Cell Anemia Information

☐ Other (be specific): _____

This Authorization (unless revoked earlier in writing) shall terminate on_____ (must have date or event filled in). By signing this authorization, I acknowledge that the information to be released may include material that is protected by federal or state law, including benefit or enrollment information; or protected health information that may include Drug/ Alcohol, HIV, or sickle cell anemia related information. My signature authorizes release of indicated information. I also understand this authorization may be revoked at any time by submitting a written request in accordance with the then current DHHS Notice of Privacy Practices (if to DHHS), or by submitting a written request to the health care provider, health care entity, or otherwise (if to anyone else),a n d it will be honored with the exception of information that has already been released. I also understand if the recipient of the information is not a health plan or health care provider, the information may no longer be protected by privacy laws.

Client's Signature		Date
Authorized Representative's Signature	Authorized Representative's Printed Name	Date

Authorized Representative (Select One): ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Personal Representative

Witness's Signature	Witness's Printed Name	Date

NOTICE TO RECIPIENT: This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (including Federal Regulations, 38 CFR 1.460-1.499, 42 CFR Part 2 and Part 431, Subpart F) which prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. The federal rules restrict the use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 CFR 2.12(c)(5) and 2.65 . A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PLEASE FILL OUT THIS FORM COMPLETELY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Nebraska Department of Health and Human Services "DHHS" and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information.

PRACTICES AND USES:

DHHS may access, use and share medical information without your consent for purposes of:

- **Treatment:** We may use your medical information to provide you with medical treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the hearing process. Different agencies within DHHS may share your medical information in order to coordinate the different things you need, or to support and maintain your continuum of care.
- **Payment:** We may use and disclose your medical information so that the treatment and services you receive can be billed. For example, we may use your medical information from a surgery you received at the hospital so the hospital can be reimbursed.
- **Operations:** We may use and disclose medical information about you for health care operations. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff.

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE WITHOUT CONSENT/AUTHORIZATION:

- **Required By Law:** We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. You will be notified, if required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.
- **Communicable Diseases:** We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight:** We may disclose Protected Health Information to a health oversight agency for activities authorized by law, or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- **Abuse or Neglect:** We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. The disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Legal Proceedings:** We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.
- **Law Enforcement:** We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Food and Drug Administration:** We may disclose your Protected Health Information as required by the Food and Drug Administration.
- **Coroners, Funeral Directors, and Organ Donation:** We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law.
- **Research:** We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board to ensure the privacy of your Protected Health Information.
- **Criminal Activity:** We may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions:** When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for military, national security, and intelligence activities. Protected Health Information may be disclosed for the administration of public benefits purposes.
- **Workers' Compensation:** We may disclose your Protected Health Information as authorized to comply with workers' compensation laws and other similar legally established programs.
- **Inmates:** We may use or disclose your Protected Health Information if you are an inmate of a correctional facility in the course of providing care to you.
- **Required Uses and Disclosures:** We must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

USES AND DISCLOSURES REQUIRING AUTHORIZATION:

There are certain uses and disclosures of Protected Health Information that require your authorization. Among them are: most uses and disclosures of psychotherapy notes; uses and disclosures of protected health information for marketing purposes; and disclosure of protected health information that constitutes a sale. Other uses and disclosures not described in this notice will be made only WITH authorization from you. You may revoke this authorization at any time as provided by 45 CFR 164.508(b)(5).

YOUR RIGHTS TO PRIVACY:

- **Right to Inspect and Copy.** You have the right to inspect and copy your medical information. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit a written request at the Site of Service or to the DHHS HIPAA Privacy & Security Office. If you request a copy, we may charge a fee for the cost of copying, mailing, and other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request the denial be reviewed.
- **Right to Amend.** If you feel that medical information about you is incorrect or incomplete, you may ask us to amend (correct) the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing and submitted at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for DHHS;
  - Is not part of the information which you would be permitted to inspect and copy; or,
  - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. You must submit your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, health care operations, and to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request for restrictions unless it is for payment or health care operations and you use your own funds to pay, in full, for a health care item or service. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing at the Site of Service, or to the DHHS HIPAA Privacy & Security Office. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of this Notice. You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, http://dhhs.ne.gov/Pages/hipaa_hp-1-p-notice.aspx or by contacting us.
- Opt out of fundraising communications. If DHHS should conduct fundraising activities, you have a right to opt out of this communication.
- Breach notification. In the event DHHS breaches your unsecured protected health information as defined by HIPAA, you will receive notification of the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with DHHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DHHS, you may contact the DHHS HIPAA Privacy & Security Office. To file a complaint with HHS, contact: Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.

CHANGES TO THE NOTICE OF INFORMATION PRACTICES

The State of Nebraska Department of Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice. DHHS will provide notice of any material change in revision of these policies either electronically or in paper format.

CONTACT INFORMATION

This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at DHHS please direct them to: HIPAA Privacy and Security Office, 301 Centennial Mall South 3rd Floor, Lincoln, NE 68509-5026, by phone at 402-471-8417, or by email to DHHS.HIPAAOffice@nebraska.gov . If you have question about your benefits call 800-383-4278. Effective:9/23/2013

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE:

_____ _____

Signature of Recipient Date

Relationship to Recipient_____