

Standard NMIS User Agency Client Authorization to Release Basic Information

Name of NMIS User Agency:					
Client's Last Name:		First Name:		Middle Initial:	
Date of Birth:		SSN: (partial acceptable)			

I authorize _____ (the Agency), as a Nebraska Management Information System (NMIS) user agency and its contracted agents, to disclose my basic identifying information to NMIS and to all of the NMIS user agencies. The disclosure will be made by entering the information into the NMIS database. Once the disclosure has been made in reliance upon this authorization, the information cannot be retrieved, and all current and future NMIS user agencies will be able to access, use, and disclose the information. The NMIS user agencies are health and human service providers who are permitted by the NMIS to access and enter data into 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 privacy regulations, 45 CFR § 164 Subpart E.

Basic identifying information authorized to be disclosed to the NMIS and made accessible to other NMIS user agencies:

Date and Time of Intake into the NMIS	Permission to Release Information
First Name, Last Name	Social Security Number and Qualifier
Medical Insurance Status	Date of Birth/Birthday
Gender	Primary Race
Ethnicity	Primary Language
Type of Living Situation	Highest Level of Education Attained
Are you Homeless? (yes or no)	Household Relationships
Zip Code of last Permanent Residence	Are you a U.S. Military Veteran? (yes or no)

I understand that I do not have to participate in the NMIS. I understand that I may revoke this authorization at any time, by doing so in writing to the NMIS user agency named above. 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.

Client's Authorizing Signature

Date (mm/dd/yy)

I also authorize the Agency to disclose basic identifying information about my dependent(s) to the NMIS.

Name(s) of Dependent(s) that the Legal Guardian Authorizes to Participate in the NMIS:

Name SS# DOB

Name SS# DOB

Name SS# DOB

Name SS# DOB

Parent or Legal Guardian's Authorizing Signature

Date (mm/dd/yy)

Printed Name and Relationship to Dependent

Agency Representative's Signature

Date (mm/dd/yy)

Agency Representative's Printed Name

Description for Informed Decision: Verbal Explanation ___ Interpreter ___ Written ___