DO NOT ALTER THIS FORM
Corrections/erasures VOID this form
Please use black or blue ink

To be used with Questions 25 and 26

FORM 7 / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Upon presentation of the original or a photocopy of this signed authorization,

*(Applicant's name)*_____

*Name of institution, doctor, or counselor*_____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Country*_____ *Province*_____

By signing below, I authorize the above provider to provide information, without limitation, relating to mental illness or the use of drugs and alcohol, including copies of records, concerning advice, care, or treatment provided to me, to representatives of the Nebraska State Bar Commission who are involved in conducting an investigation into my moral character, professional reputation, and fitness for the practice of law. I understand that any such information as may be received will be reported only to the Nebraska State Bar Commission. The information will be used or disclosed at my request. This authorization will expire one year from the date of my notarized signature below.

I hereby release, discharge, and exonerate the Nebraska State Bar Commission, its agents and representatives, and the above named provider, its agents and representatives so furnishing information from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, and other information, or out of the investigation made by the Nebraska State Bar Commission.

I do not have to sign this authorization in order to receive treatment from the above provider. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be resubmitted to the privacy officer at the address of the provider above.

_____

Signature of Applicant *Date*

STATE/DISTRICT OF_____

COUNTY/PARISH OF_____

Subscribed and sworn to or affirmed before me this_____day

of_____, _____
Month *Year*

_____

Signature of Notary Public

My commission expires_____

Seal or stamp must be affixed to each original.

The Nebraska State Bar Commission is aware of HIPAA requirements.