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

Nebraska Department of Health and Human Services Authorization for Release of Information

Office/Unit

Applicant or Client SHOULD NOT SIGN UNTIL all Blanks Have Been Filled in

Last Name	First Name		Middle Initial(s)	
Street or Mailing Address		City		
State	Zip Code	Case Number/Socia	l Security Number	
I authorize the release of infrepresentatives of the Nebra (One source only. Use additional contents of the Nebra (One source only).	formation regarding my aska Department of Health and Human Ser onal form for each additional source)	vices. Such privileged infor	situation to mation shall be released by:	
Only during the one (1) year	following the below given date.			
Signature of Applicant or Client SIGN HERE		Date	Date	
Signature of Spouse, if not separated from applicant or client SIGN HERE		Date		
Signature of Witness SIGN HERE		Date		
_		ASD-46 Rev. 5/20	119 (Previous version 11/11 should be used first)	
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