University of Nebraska Medical Center

Developmental TIPS

Authorization for Exchange of Information

HOSPITAL #

DOB

Full Name of Patient

I hereby grant permission for Development TIPS and for the persons, agencies and/or schools (or the authorized representatives of those persons, agencies and schools) listed below to exchange information related to the above patient's condition(s), assessment and/or treatment. Such information may contain any or all portions of the patient's record in the possession of those persons, agencies, schools, Munroe-Meyer Institute and/or authorized representatives thereof.

Name of Individual, Agency or School	Name of Physician, Individual, Agency or School
Munroe-Meyer Institute	
985450 Nebraska Medical Center	
Street Address	Street Address
Omaha **Nebraska** **68198-5605**	
City State Zip	City State Zip

Specific Information

- [x] TIPS Follow-up Reports
- [x] Health Data
- [x] Other

Authorization expires 6 months after it is signed.

This statement of consent can be revoked at any time before disclosure of the information.

Authorized by: Date:

Relationship to Patient

Witnessed by: Date:

Staff Position of Witness

MMI