McCook Clinic, P.C.

Authorization to Use or Disclose Protected Health Information

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

(Previous/Maiden Name, if applicable): _____

I authorize and request release of my medical records:

FROM:	**TO:**
Facility/Individual Name: _____ Address: _____ _____ Phone: _____ Fax: _____	McCook Clinic, PC PO Box 1207 1401 East H Street McCook, NE 69001 Phone: (308) 344-4110 Fax: (308) 344-8369

Date Range of Records to be Disclosed:	**From:** _____ **To:** _____

Information to be Disclosed (will include McCook Clinic records only)		
☐ Office Notes	☐ Surgical Reports (ie. colonoscopy reports)	☐ Problem List
☐ Laboratory Results	☐ Immunization Record	☐ Allergy List
☐ Radiology Reports (ie. x-ray,ultrasound, CT/MRI, mammogram)	☐ Medication List	☐ Other:

SENSITIVE INFORMATION: This authorization includes the release of the following sensitive information unless specifically excluded. **Please check if you <u>DO NOT</u> want this released:**

☐ HIV/AIDS ☐ Sexually Transmitted Diseases ☐ Alcohol/Drug Abuse ☐ Behavioral/Mental Health

Reason for this Authorization:	☐ Continuation of Care ☐ Transfer of Care ☐Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact (Nichole Hartzer, RHIT, HIM Director/Privacy Officer, or Brian Rokusek, Office Manager/Security Officer).

_____ _____

(Signature of Patient) **(Signature of parent, guardian, or authorized representative)**

_____ _____

(Date) **(Relationship to Patient)**

Initials of Staff Preparing Authorization: _____