McCook Clinic, P.C.

Phone: 308-344-4110 1401 East H Street, P.O. Box 1207 McCook, Nebraska 69001 Fax: 308-344-8369

Authorization to Disclose Health Information

All * items MUST be completed prior to release of records

*Patient Name:_____ Health Record Number:_____

*Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

*Facility/Individual Name: _____ Telephone #: _____

*Address: _____ Fax #: _____

*City/State/Zip code: _____

*3. The type and amount of information to be used or disclosed is as follows: (include dates):

_____ Clinic record from (date)_____ to (date)_____
_____problem list _____medication list
_____list of allergies _____immunization record
_____laboratory results from (date)_____to (date)_____
_____x-ray and imaging reports from (date)_____to (date)_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

McCook Clinic, P.C.
PO Box 1207
1401 East H Street
McCook, NE 69001

***FOR THE PURPOSE OF:**_____

6. 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.

7. 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, HIM Director/Privacy Officer, or Brian Rokusek, Office Manager/Security Officer*).*

*_____ * Date _____

Signature of Patient or Legal Representative (Relationship to Patient) *Phone #_____

FOR OFFICE USE ONLY: Mail_____ Pick up _____ Appt Date _____ Records needed by _____
Initials of Staff Preparing Authorization _____ Date Processed:_____ Initials: _____