2115 N. Kansas Avenue Hastings, NE 68901 402-463-2454

AUTHORIZATION TO OBTAIN AND RELEASE PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ___/___/___

☐ Disclose To ☐ Obtain From

Organization or Individual ______________________

Address ______________________

City and State ______________________ Zip ____________

Pertaining to the following information from my medical record:
Dates of treatment ______________________

☐ Complete Records ☐ Discharge Summary ☐ Xray
☐ Lab Tests ☐ History & Physical ☐ Other
(Please specify)____________

Purpose for which information is to be used:
☐ Treatment ☐ Legal ☐ Personal ☐ Other

I understand that the information in my records may include information related to sexually transmitted diseases, AIDS, HIV infection and/or drug, alcohol and mental health related treatment.

I understand I can revoke this authorization at any time. I understand the revocation will be made in writing and will not pertain to information that has already been released. This authorization will expire 6 months from the date it is signed. A photocopy of this authorization shall be considered as valid as the original.

SIGNATURE of Patient or Representative ______________________

Date ____________ Witness ______________________

Relationship of Representative to Patient ______________________

Records Release on (date) ____________ By (name) ______________________