BOONE COUNTY HEALTH CENTER
AND MEDICAL CLINICS
723 West Fairview Street
P.O. Box 151
Albion, NE 68620

402-395-2191 - Hospital
402-395-5013 – Boone County Medical Clinic
402-395-5165 – Fax (HIM)

Authorization for

RELEASE OF HEALTH INFORMATION

By signing this form, you permit Boone County Health Center and/or Medical Clinics to disclose your confidential personal health information.

1. **PATIENT** – The patient whose information may be released is:
   Name ____________________ **D.O.B.** ____________
   Address____________________ **Phone Number**____________
   City, State, Zip____________________ **MRN:**____________

2. Release Records FROM:
Provider ____________________
Name ____________________
Address ____________________
City__________ State_____ Zip______

TO:
____
____
____
____

3. **Dates of Service or Time Period of records to be disclosed: (If dates are not provided only the past year will be sent.)**
Current 1 Year 2 Years
0.25 copy fee may apply (personal or legal reasons)

4. Purpose of Disclosure:
☐ *Transfer of Care* ☐ Consultation ☐Referral ☐ Personal Record ☐ Disability ☐ Other ___________

5. Health Information to be Disclosed:
☐History & Physical examination ☐Progress Notes ☐Lab Reports ☐X-Ray Reports
☐Emergency Room Record ☐Consultation Reports ☐EKG/Cardiac Records ☐Immunization Record
☐Therapies (PT, OT, ST) ☐Billing Information ☐Discharge Plan ☐Discharge Report
I specifically authorize the release of information relating to:
☐Substance abuse _______ Please initial
☐Mental health ______ Please initial
☐HIV/AIDS related information (including test results) ______ Please initial

Information disclosed by (select one): Paper copies [ ] Fax [ ] CD [ ] USB Memory Stick/ Thumb Drive [ ]
I understand and acknowledge that:

- My refusal to sign this authorization will not affect my ability to obtain treatment at BCHC.
- Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
- This authorization is effective for _____ months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to Health Information Management. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
- I have read (or had read to me) and have received a copy of this document.
- I realize I will be charged a copy fee of : 0:25 cents per page plus postage. Signature________________

____ ________________
Signature of patient or patient's personal representative / relationship **Date**
Verified with photo identification and copied ______________________ **(Employee)**

________________________ ________________________
Authorization prepared by (Employee)/ Date **Records** prepared by (Employee)/Date