**BOONE COUNTY HEALTH CENTER**

**AND MEDICAL CLINICS**

**1173 South 8th Street** 402-395-2191 – Hospital (Telephone)

**P.O. Box 151** 402-395-5013 – Boone County Medical Clinic (Telephone)

**Albion, NE  68620 402-395-2180 – Fax**

**Authorization for RELEASE OF PROTECTED HEALTH INFORMATION**

**By signing this authorization form, you permit Boone County Health Center and/or Medical Clinics (BCHC) to disclose your protected health information as described below.**

**Patient Name (please list previous last name if applicable)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ST\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Authorize Boone County Health Center to: (Check One for Information to be Released or Requested)**

\_\_\_\_\_\_\_\_ Release Information To: OR \_\_\_\_\_\_\_\_ Obtain Records From:

Facility/Provider/Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/St/Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Disclosure (Check One)**

\_\_\_\_ Patient Request \_\_\_\_Other

**Date(s) of Service to be Disclosed (Check One)** (copy fees may apply in accordance with Nebraska law)

\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert date range) \_\_\_\_All Dates of Service

**Health Information to be Disclosed (Check all that apply)**

\_\_\_\_All \_\_\_\_Clinic Notes \_\_\_\_Laboratory \_\_\_\_Cardiac (Specify) \_\_\_\_Immunizations

\_\_\_\_Therapy OT, PT, ST \_\_\_\_Hospital Notes \_\_\_\_Radiology \_\_\_\_Operative Record

\_\_\_\_Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I specifically Authorize the release of Information relating to:* Please initial each you authorize.**

**\_\_\_\_ Substance Abuse \_\_\_\_ Mental Health \_\_\_\_ HIV/AIDS related information**

**Format for Disclosure: (Check One)**

\_\_\_\_ Paper Copies \_\_\_\_ Fax \_\_\_\_ CD \_\_\_\_ Encrypted Email \_\_\_\_ Other (if feasible) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand and acknowledge that:**

\*My refusal to sign this authorization will not affect my ability to obtain treatment at BCHC.

\*Medical information 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 twelve (12) months from the date of signature. I understand that I may revoke this authorization at any time by giving written notice to BCHC’s Heath Information Management (HIM) Department. 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.

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Witness (Employee):** Must attach **photocopy ID** for person responsible for picking up records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_