

723 West Fairview Street PH. 402-395-2191

PO Box 151 FX. 402-395-2180

Albion, NE 68620

**HIPAA CONTACT INFORMATION**

**PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_(Initial) Boone County Health Center (BCHC) is permitted to share **any and all** medical information with the following individuals listed below, including test results, sensitive information as stipulated by the State of Nebraska, and information disclosed during hospital and/or office visits. **The following are exceptions of information I do NOT want shared:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark an (X) in the appropriate column if you would like to authorize someone to receive your medical and/or billing information. Also, please be sure to list your Healthcare Power of Attorney and provide BCHC a copy of your Healthcare Power of Attorney form. Thank you.

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| **NAME** | **RELATIONSHIP** | **PHONE NUMBER** | **RELEASE MEDICAL INFORMATION** | **RELEASE BILLING INFORMATION** |
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*This is not a substitute for a Release of Information form to obtain medical records.*

I UNDERSTAND AND DIRECT THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL IT IS REVOKED BY ME IN WRITING.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MRN#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_