

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Sarpy County OB-GYN, P.C. 1413 S. Washington St Suite 270 Papillion NE 68046 Phone 402-898-8500 Fax 402-898-8510

I hereby authorize _____

(Name of Provider)

(Address) (City) (State) (Zip Code)

to disclose the following information from the PHI of:

Patient name: _____ Date of Birth _____
(Last) (First) (M/I) (Month/Day/Year)

Address: _____ City/State _____ Zip Code _____

Covering the period(s) of health care from _____ to _____

INFORMATION TO BE DISCLOSED

- | | |
|---|---|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Office Visits |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Echo Video/X-Ray Films |
| <input type="checkbox"/> Miscellaneous Test Results/Reports | |
| <input type="checkbox"/> Other (specify) _____ | |

I understand that this will include information relating to (check if applicable)

- Acquire immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
 Behavioral health services/psychiatric care
 Treatment for alcohol and/or drug abuse

This PHI is to be disclosed to:

Name of provider, person, facility or institution: _____

(Address) (City) (State) (Zip Code)

(Telephone) (Fax)

for the purpose of _____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire 180 days from the date of signature.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically permitted by appropriate state or federal law.

Signed: _____ Dated: _____
(Patient) (Month/Day/Year)

(or legal representative) (relationship to patient) Date: _____
(Month/Day/Year)