

Phelps Memorial Health Center  
1215 Tibbals St., Holdrege, NE 68949  
Patient Authorization to Disclose Health Information

Patient Name: \_\_\_\_\_

Address (Street, City, State & Zip Code): \_\_\_\_\_

Health Record # \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's health information, as described below.

2. Phelps Memorial Health Center; 1215 Tibbals; Holdrege, NE 68949, is authorized to make the disclosure.

3. The type and amount of information to be used or disclosed is as follows (check the appropriate item(s), and include other information, where indicated):

- Most recent history and physical
- Laboratory results from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
- X-ray and/or imaging reports from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_
- Consultation reports from (please list doctor's name(s) \_\_\_\_\_
- \_\_\_\_\_
- Most recent discharge summary
- Other (please describe) \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to, and used by, the following individuals or organizations:

Name: \_\_\_\_\_  
Address (Street, City, State & Zip Code) \_\_\_\_\_

6. This information is being disclosed for the following purpose(s): \_\_\_\_\_

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Phelps Memorial Health Center, 1215 Tibbals, Holdrege, NE 68949. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following:  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Event: \_\_\_\_\_; or  
Condition: \_\_\_\_\_

9. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
10. I understand that I am under no obligation to sign this form and that Phelps Memorial Health Center may not condition treatment on my decision to sign this authorization, subject to the following exception: If my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, then Phelps Memorial Health Center may refuse to treat me if I do not sign this authorization.
11. If I have questions about disclosure of my health information, I can contact the HIM Leader at (308) 995-2211.
12. I understand that I will be given a copy of this authorization form, after signing.

Signature of Patient or Legal Representative: \_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If signed by legal representative, relationship to patient: \_\_\_\_\_

Evidence of the representative's authority to act on the individual's behalf must be included in the patient record or attached.

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Eff 3/31/03)