Midlands Healthcare Group

611 West Francis St. Ste 100
North Platte, Ne 69101
Phone: 308-534-2532
Fax: 308-534-6615
www.midlandshealthcare.com

Midlands Family Medicine
Midlands Occupational Medicine
Midlands Internal Medicine
Family Medical Center

Authorization to Disclose Protected Health Information

This form is for all record requests.

RELEASE INFORMATION FROM: Specify Provider/Organization Name and Facility Address Organization Name:_____ Address:_____ _____ _____	**RELEASE INFORMATION TO:** Specify Provider/Organization Name and Facility Address Organization Name:_____ Address:_____ _____ _____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/____/_____ **SSN/MEDICAL RECORDS #** _____

ADDRESS_____

Mailing Address, City, State, Zip

_____

Covering the period(s) of health care:

FROM (Date) _____/_____/_____ TO (Date) _____/_____/_____

1. Information authorized for disclosure, if included in my records:
   - ☐ Complete Health Record
   - ☐ Visit/Discharge Summary
   - ☐ Clinical Documentation of Physical
   - ☐ Documentation of Consultation
   - ☐ Immunization Records
   - ☐ Progress Reports
   - ☐ Radiology and Diagnostic Imaging Reports
   - ☐ Photographs, Videos, Digital or Other Images
   - ☐ Pathology Reports
   - ☐ Laboratory tests (please specify)
   - ☐ Other (please specify)

2. If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed (please initial below):

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- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- ☐ Behavioral Health Services/Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic Counseling/Testing

_____ I understand that the information disclosed pursuant to this Authorization, except information
initial protected by Federal and/or State regulation about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. The purpose of which disclosure is authorized (check where applicable):
☐Medical Care ☐Insurance ☐ Benefit eligibility ☐Immunization

Other:_____

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. 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 review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
(Date) ____/____/_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here_____) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.
5. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.
6. This 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.

Signed: Patient – (or Legal Representative, Parent, or Legal Guardian) (Relationship if not Patient)
ID Provided_____ Date ____/____/_____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or the court.

Official Use Only
Name/Title of Person Releasing Information: _____
Date ____/____/_____