Family Practice of Grand Island, PC 12/12/05

2116 W Faidley Ave, Ste 400
Grand Island, NE 68803
Phone 308-381-0162 Fax 308-389-4445

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

(Please complete in ink. Attach copy of ID for verification.)

Patient Name _____ Previous Name _____
Date of Birth_____ SS #_____ Acct #_____

I give written authorization for verbal &/or written PHI disclosure on the patient named above:

FROM: (CLINIC/MD)_____ TO: _____
Address_____ Address_____
City, State, Zip_____ City, State, Zip _____
Phone_____ Phone_____ Fax#_____
DOB_____ Relationship_____

Disclosure Purpose: ___Transfer of PHI ___ Marketing (non face to face) ____Legal
___ Insurance applications ___ Employment Determinations ____Research
___Other_____

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law. This authorization applies to:

_____ Complete PHI (medical record)
_____ PHI relating to the following condition(s), test(s) or date(s) of treatment: _____
_____ Other _____

If the PHI release that I have authorized directly above includes any of the following *highly protected health information*, I give specific authorization to release this highly protected health information for which I may have been tested, diagnosed or treated. (Please initial each as applicable.)

_____Drug use, Alcohol use, Substance Abuse _____HIV, AIDS
_____Mental health (Psychotherapy notes prohibited by law) **_____Sexually transmitted diseases**

This information has been disclosed to the above named party from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits further disclosure of *highly protected health information* without specific written authorization of the person to whom it pertains. A general authorization for the disclosure of highly protected health information is NOT sufficient for this purpose.

If applicable and unless directed otherwise by court order, the legal personal representative of a patient, biological parent or legal guardian of a minor (<19 years of age) are the individuals whose responsibility it is to authorize disclosure of the patient's PHI. In the case of a minor consenting to their own services for STD or chemical dependency, the minor and only the minor may authorize disclosure of PHI pertaining to these conditions.

I understand refusal to authorize my PHI disclosure does not effect my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

_____ _____
Patient Signature Date

_____ _____ _____ (Documentation attached)
Personal Representative Signature Relationship Date

_____ _____
Notary or Witness Signature Date

This authorization **expires Six Months** after the date of signature **OR in the event** _____(e.g. of my death, end of research study). However, this authorization may be revoked at any time, through written notice to Family Practice of GI, if received prior to the disclosure of PHI. A photocopy of this authorization shall be considered as valid as the original.

Revocation by _____on _____witnessed by _____
Patient or PR signature Date FP witness signature

Family Practice Use Only (see reverse side)

Date Needed _____ Date FP received _____
☐ Date Sent US Mail _____ **MD/PA Signature** _____
☐ Date Picked up _____ FP Staff Signature _____

- ❑ $_____ Fee for this request ($20 handling plus $0.50/page copied and/or cost-based/x-ray film copied)_____
- ❑ No fee for this request
- ❑ Signed completed authorization form was given to patient/personal representative
- ❑ Signed completed authorization form was given to recipient of disclosed PHI