Family Practice of Grand Island, P.C.

3563 Prairieview St, Ste 300
PO Box 9802
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 _____
Address _____
City, State, Zip _____
Phone _____

TO _____
Address_____
City, State, Zip _____
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
_____Mental Health (Psychotherapy notes prohibited by law)
_____HIV, AIDS
_____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 affect 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

_____ _____
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 Grand Island, 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

Date Needed _____Date FP Received _____ **MD Signature** _____
Date Sent US Mail _____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

Family Practice of Grand Island, PC

Designated Record Set

Business Office	**Medical Record**
Itemized Statement	Demographic Information
Explanation of Benefits	Medical Care Information
Status of Account	National Registry Information
Bank/Loan Information	Diagnostic Information
Medicare/Insurance Card copies	PHI Authorizations/Amendment Requests
Encounter Form	Insurance Referrals/Information
	Financial Responsibility Information
	Scanned Images

Not part of the designated PHI record set (not subject to amendment requests)
Insurance Requests
Subpoenas
Power of Attorney/Living Wills
Employment Records
De-identified Information
Family Education Rights and Privacy Act (FERPA) Records
Unincorporated PHI from outside source stating no Redisclosure
Oral PHI unless it is documented and used to make decisions

Permitted or Required PHI Use and Disclosure

1. **No patient *authorization*** is required to use or disclose PHI for:
    a. TPO-Treatment, Payment or Other Healthcare operations - Family Practice policy is to obtain *consent* for TPO
    b. Department of Health and Human Services (DHHS)
    c. Public Health
    d. Federal Drug Administration (FDA)
    e. Health oversight agencies
    f. Workers compensation
    g. Coroners, medical examiners, funeral directors
    h. Legal proceedings
    i. Law enforcement
    j. Criminal activity
    k. Correctional institution
    l. Military activity and National Security
    m. Face-to-face marketing
    n. Business associates
    o. Organ, eye and tissue procurement organizations
2. Patient may limit the use or disclosure of PHI in certain situations. See complete NPP.