AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
BOX BUTTE GENERAL HOSPITAL AND AFFILIATED CLINICS

I hereby authorize (Name of Provider)_____to disclose the following information from the health records of:

Patient Name_____ M.R.# _____ Date of Birth_____

Address_____ Telephone_____

Covering the period(s) of healthcare
From (date) _____ to date)_____

Information to be disclosed:

_____Complete Health Record
_____ History and Physical
_____Consultation Reports
_____X-ray Reports
_____Other_____
_____Discharge Summary
_____Progress Notes
_____Laboratory Tests
_____Radiology Films
_____Emergency Room Record

I understand that this will include information relating to (check if applicable)
_____ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
_____ Behavioral health services/psychiatric care
_____Treatment for alcohol and/or drug abuse

This information is to be disclosed to_____.
Purpose of disclosure _____.
This person/entity may re-disclose this information to others without your permission and is not protected by the HIPAA Privacy regulations.

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 in 120 days.
I have received a copy of Box Butte General Hospital's Notice of Privacy Practice.
The facility, its employees, officers, and **p**hysicians 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 Personal Representative) (Date)

Signed_____ _____
P.O.A. (Power of Attorney document attached) (Date)

Signed _____ _____
(Witness) (Date)

Please indicate reason patient could not sign and extent of your authorization to receive such medical records _____
_____

Request completed on_____ (Date) by_____ (initial)

NOTE: For a Chemical Dependency Release of Information.
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."