Authorization To Use And Disclose Protected Health Information

Mary Lanning Medical Clinics

COMMUNITY HEALTH CENTER
HASTINGS FAMILY PLANNING
606 North Minnesota
Hastings, NE 68901
Phone: 402-461-5265
Fax: 402-461-5270

HASTINGS FAMILY CARE
223 East 14th, Suite 100
Hastings, NE 68901
Phone: 402-463-2929
Fax: 402-463-2939

BLUE HILL CLINIC
102 North Pine
P.O. Box 547
Blue Hill, NE 68930
Phone: 402-756-2141
Fax: 402-756-2142

DONIPHAN FAMILY CARE
2011 West Clarice St.
P.O. Box 281
Doniphan, NE 68832
Phone: 402-845-2903
Fax: 402-845-2904

EDGAR MEDICAL CLINIC
315 North C
P.O. Box 406
Edgar, NE 68935
Phone: 402-224-3344
Fax: 402-224-3099

WOOD RIVER FAMILY CARE
905 Main St
P.O. Box 549
Wood River, NE 68883
Phone: 308 583-1060
Fax: 308-583-1068

Patient Name:_____ Date of Birth:_____ Phone #:_____

I hereby authorize:

❑ Community Health Center / Hastings Family Planning ❑ Hastings Family Care ❑ Blue Hill Clinic

❑ Doniphan Family Care ❑ Edgar Medical Clinic ❑ Wood River Family Care

To: ❑ Give To ❑ Get From

Organization or Individual:_____

Phone number:_____ Fax number:_____

Relationship to Patient:_____

Street Address:_____

City and State:_____ Zip:_____

Dates of Treatment:_____

Information to be Disclosed:

❑ Consultation Report ❑ Financial Record ❑ Radiology Reports ❑ Office Notes
❑ Demographic ❑ History and Physical Exam ❑ Pathology Report ❑ Verbal Communication
❑ Discharge Summary ❑ Lab ❑ Other:_____

Purpose for which information is to be used:

❑ Treatment ❑ Insurance / Payers ❑ Personal
❑ Legal Proceedings ❑ Other (specify)_____

If records are requested to be given directly to me, I understand that payment is due at signing before they are copied.

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

I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to this authorization. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless previously revoked, this authorization will expire _____ from date of signature. I consider a photocopy of this authorization to be as valid as the original.

My refusal to sign this authorization will not affect my ability to obtain treatment at Mary Lanning Healthcare. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness If signed by Legal Representative, state Relationship to Patient