Authorization for Release of Health Information (04/14/03)

Implemented 04/14/03

Name:________________________________ DOB/ID #:____________________________

Mailing Address:____

Phone Number:________________________________

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize:

____

____

____

to use or disclose to:

____

____

____

the following protected health information *(identify the information in a specific and meaningful fashion)*:

____

____

____

The purpose of the use or disclosure is *(describe each purpose of the requested use or disclosure)*:

____

____

____

Redisclosure of Information - I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. Alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the recipient must be informed that redisclosure is prohibited except as permitted or required by law. The Notice of Privacy Practices describes the circumstances where disclosure is permitted or required by these laws.

Right to Refuse to Sign this Authorization - I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment or eligibility for health care benefits on my decision to sign this authorization.

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Right to Revoke - I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it.

Right to Inspect - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. The procedure for how I may inspect or copy my health information is explained in the City of Lincoln's Notice of Privacy Practices, a copy of which has been previously provided to me.

Right to Receive a Copy of Authorization - I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form.

Expiration Date - I understand that unless revoked, this Authorization will expire automatically upon

______________________________________. *(Date or event related to the purpose of authorization)*

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient:____

Please print name:____

Date: _____/_____/____

- or -

Signature of Authorized Representative: ____

Please print name:____

Please explain Representative's authority to act on behalf of the Patient: __________________________

____

Date: _____/____/____