Harlan County Health System

717 North Brown
P.O. Box 836
Alma, NE 68920-0836
phone (308) 928-2151
fax (308) 928-2774
www.harlancountyhealth.com

Authorization for Release of Information

Patient Name: ______________________ DOB: ____________ MRN: ______________

I, ______________________, authorize Harlan County Health System to disclose confidential health information from the above named patient's health information to

Physician: ______________________
Facility: ______________________
Address: ______________________
Phone: ______________ Fax: ______________

for the following purpose: ______________________.

The information to be disclosed is:

- ☐ Billing information
- ☐ Diagnostic study results (laboratory, radiology, pathology) ______________
- ☐ Discharge instructions
- ☐ Emergency Department record
- ☐ Immunization records
- ☐ Medication records
- ☐ Multi-disciplinary notes
- ☐ Procedure reports
- ☐ History and Physical Examination
- ☐ Therapy/rehabilitation records

For treatment dates of ______________________.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.

This authorization will expire on the following date or event: ______________________.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact:

Privacy Officer/Contact Person
717 North Brown PO Box 836
Alma, NE 68920
308-928-2151

______________________ ______________________
Signature of Patient or Patient's Personal Representative Date

Personal Representative's Relationship to Patient: ______________________

______________________ ______________________
Witness Signature Date