KEARNEY COUNTY
HEALTH SERVICES

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name ____ Date of Birth ___________________

Patient's Address____

I hereby authorize: Kearney County Health Services
727 East First Street
Minden, NE 68959

To: ______Disclose to
______Obtain from

Organization or individual____
Street Address____
City and State____Zip________________________

Date(s) of Service: ____

Information to be disclosed:

___Complete Health Record	___Discharge Summary
___Consultation Reports	___History & Physical
___Laboratory tests	___Office Visits
___Radiology Reports	___Miscellaneous Test Results/Reports
___Radiology Films/Images	___Emergency Room Record

___Other (Specify) ____

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

Purpose for which information is to be used:

____Treatment ____Insurance/Payers ____Personal
____Legal Proceedings ____Other (Specify) ____

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 automatically expire twelve (12) months from date of signature for same request. I consider a photocopy of this authorization to be as valid as the original.

I understand that authorizing the disclosure of protected health information is voluntary and that I can refuse to sign this authorization. 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

____ ______________________________
If signed by legal representative, relationship to patient Signature of Witness