Revised 08-18-18

KEARNEY COUNTY HEALTH SERVICES
727 East First Street Minden, NE 68959
Phone: 308-832-3400 Fax: 308-832-3415 www.kchs.org
Minden Medical Clinic ~ Kearney County Hospital

## 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**
**___Consultation Reports**
**___Laboratory tests**
**___Radiology Reports**
**___Radiology Films/Images**
**___Discharge Summary**
**___History & Physical**
**___Office Visits**
**___Miscellaneous Test Results/Reports**
**___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