PATIENT AUTHORIZATION FORM

Brown County Hospital

Ainsworth Family Clinic and BCH Specialty Clinic

945 East Zero Street * Ainsworth, NE 69210 * 402-387-2800

Fax: 387-2804

Patient Information:	Name:		
	Address:		
	City:	State:	Zip:
	Date of Birth:	Phone:	SSN:
Release Records From:	**I authorize the following facility/provider to release my health information from:**		
	Name:		Phone:
	Address:		Fax:
	City:	State:	Zip:
Send Records to:	**I authorize my health information to be disclosed to:**		
	Name:		Phone:
	Address:		Fax:
	City:	State:	Zip:
Health Information to be disclosed:	☐ Physician Office Notes	☐ Consultation Reports	
	☐ Discharge Summary	☐ Lab or Path Report	
	☐ History and Physical	☐ Imaging (X-Ray,Mammo, Nuc-Med) Reports/Disk	
	☐ Procedure Notes	☐ Other: (specify) _____	
Dates of Service:	**If no date is specified the last 24 months will be sent**		
	From:_____	To:_____	
Purpose:	☐ Change of Doctor	☐ Consult/Second Opinion	
	☐ Disability	☐ Legal	
	☐ Personal	☐ Continuation of Care	
	☐ Process Insurance Claims	☐ Other: _____	
Revocation:	**I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I understand that this authorization will be in effect for 90 days from the date signed unless revoked by me in writing.**		
Re-Disclosure:	**Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage. I further understand that information to include alcohol, drug abuse, communicable disease including HIV STATUS, AND/OR PSYCHIATRIC DIAGNOSIS MAY HAVE BEEN COMPILED DURING MY VISITS, ENCOUNTERS OR HOSPITALIZATION and that I will not hold the facility or its employees liable for releasing information at the patients request. *NOTICE TO RECEIVING AGENCY OR INDIVIDUAL:* This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.**		
Patient Signature:	Patient's Authorized Signature or Personal Representative Signature with a POA on file:		Date:
	Relationship to Patient:		Time:

Office Use Only:	Date/Time:	Method:	Logged By:
Records Released By:	# of Pages:	☐ If records picked up was ID verified?	Date: