AUTHORIZATION TO DISCUSS PHI

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:	SS#:
Disclose Information From:	**I authorize Brown County Hospital, Ainsworth Family Clinic, and Specialty Clinic to disclose specific information described below:**		
Information to be Given to:	**I authorize my health information to be disclosed to:**		
	Name:	Name:	
	Relationship:	Relationship:	
	Address:	Address:	
	Phone:	Phone:	
	Name:	Name:	
	Relationship:	Relationship:	
	Address:	Address:	
	Phone:	Phone:	
Dates Authorization Valid:	**This authorization shall remain in effect from dates listed below:**		
	If No Date is listed, the form expires in 5 years.		
	From:_____	To:_____	
Description of specific information to be discussed:	☐ Appointment Date/Times	☐ Medications	
	☐ Diagnosis	☐ Lab Tests/Results	
	☐ X-Ray Results	☐ Other (specify)	
	☐ Patient Account Information		
I understand that:	• **I may inspect or copy the protected health information to be used or disclosed.** • **I may revoke this authorization in writing by contacting your office.** • **This authorization is giving Brown County Hospital the right to discuss my medical information with the one or more people listed above.** • **Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.** • **I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.**		
Patient Signature:	Patient's Authorized Signature or Personal Representative Signature with a POA on file:	Date:	
	Relationship to Patient (if signed by personal representative of patient):	Time:	