BOX BUTTE GENERAL HOSPITAL

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize (Name of Provider) _____to disclose the following information from the health records of:

Patient Name: _____ M.R.#_____ Date of Birth:_____
(Please Print)

Address: _____ City: _____ State: _____ Zip:_____ Phone: _____

Covering the period(s) of healthcare from: (date) _____ to (date) _____

Information to be disclosed:

_____Complete Health Record
_____History and Physical
_____Consultation Reports
_____Imaging reports
_____Other_____
_____Discharge Summary
_____ Progress Notes
_____Laboratory Tests
_____Imaging CD/DVD
_____Emergency Room Record

Imaging Exams _____

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

This information is to be disclosed to_____.
The purpose of this disclosure is_____.
This person/entity may re-disclose this information to others without your permission and is not protected by the HIPAA Privacy regulations.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 120 days.
I have received a copy of Box Butte General Hospital's Notice of Privacy Practice.
The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ _____
(Patient or Personal Representative) (Date)

Signed: _____ _____
P.O.A. (Power of Attorney document attached) (Date)

Signed:_____ _____
(Witness) (Date)

Please indicate reason patient could not sign and extent of your authorization to receive such medical records:

_____

Request completed on _____ by _____.
(Date) (Initial)

****

Note: For a Chemical Dependency Release of Information.
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Date to be picked up: _____ Call when ready: _____