Auburn Family Health Center, P.C.
2115 14th Street, Suite 100
Auburn, NE 68305
Phone: (402) 274-4993 Fax: (402) 274-4905

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____ **D.O.B.**_____

Address_____ **Phone #**_____

I, hereby authorize… _____
Facility Name

_____
Address

_____
Phone

…to use and/or disclose my health information as follows:

DiscloseTo:_____
Recipient Name Phone Number

_____
Recipient Address

Purpose(s) of Disclosure:_____

- ☐ Check this box if disclosure is at the request of the individual.
- ☐ If the purpose for the disclosure is marketing, check this box only if AFHC *will* receive direct or indirect remuneration from a third party.

Information to be Disclosed:

- ☐ History and Physical Examination
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ X-ray Reports
- ☐ Consultation Report
- ☐ Emergency Room Record
- ☐ Discharge Report
- ☐ After Care Plan
- ☐ Financial Record
- ☐ Complete Record

I specifically authorize the release of information relating to *(please initial & check box):*

_____ ☐ Substance Abuse (Including Alcohol/Drug Abuse)
_____ ☐ Mental Health
_____ ☐ HIV/AIDS Related Information (Including Test Results)

Dates of Service or Time Period of Records to be Disclosed:_____
(State time period or "all")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at AFHC.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
3. This authorization is effective for 12 months after the date it was signed unless prior notice of termination is received. I understand that I may revoke this authorization at any time by giving written notice to medical records. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date

_____
Relationship to patient if signed by personal representative