Authorization to Disclose Health Information

Prairie Shoulder, Elbow & Hand Center, PC (PSEH)

Patient:

_____ _____
Name of Patient Birth Date/Medical Record Number

_____ _____
Street Address City, State, Zip Phone

Authorizes:

Prairie Shoulder Elbow and Hand Center, PC
1730 S 70th St, Suite
Lincoln, NE 68506

Release of Protected Health Information To:

_____
Name of Health Care Provider/Plan/Other

_____
Street Address

_____
City, State, Zip Phone

Information To Be Released:

__Problem List
__Medication List
__Allergy records
__Consultations
__Office Notes
__Other (Specify):_____

__Surgical/Operative Reports
__Hospital Records including reports
__Laboratory Reports
__Physical Therapy Notes

__Immunizations
__X-ray Reports
__Prescriptions
__Entire Record

Dates: From_____ To_____

Purpose For Need Of Disclosure: (Check applicable categories)

__Further Medical Care
__Insurance Eligibility/Benefits
__Other (Specify):_____

__Legal Investigation
__Changing Physicians

__Personal

I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form as provided in CFR 164.524. I may arrange to inspect my health information or obtain copies by contacting PSEH.

Right to Receive Copy of this Authorization: I understand that if I agree to sign this authorization, which I am not required to do, I am entitled to a signed copy.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and I need not sign this form in order to assure treatment at PSEH.

Right to Withdraw This Authorization: I understand I have the right to revoke this authorization at any time and that written notification to PSEH is required to do so. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that PSEH has already made in reference to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration Date: Unless otherwise revoked, this authorization will expire on the following date_____ or one (1) year from the date signed.

I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the PSEH Privacy Officer at 402-489-4700.

Signature of Patient or Legal Representative:_____ **Date:**_____
(If signed by other than patient, state relationship and authority to do so.)

Witness:_____