**BOONE COUNTY HEALTH CENTER**
**AND MEDICAL CLINICS**
**1173 South 8th Street**
**P.O. Box 151**
**Albion, NE 68620**

402-395-2191 – Hospital (Telephone)
402-395-5013 – Boone County Medical Clinic (Telephone)
**402-395-2180 – Fax**
Roi@boonecohealth.org - E-mail

# Authorization for RELEASE OF PROTECTED HEALTH INFORMATION

**By signing this authorization form, you permit Boone County Health Center and/or Medical Clinics (BCHC) to disclose your protected health information as described below.**

**Patient Name (please list previous last name if applicable)**

_____

DOB_____

Address_____ Phone #_____

City_____ST_____ZIP_____

## I Authorize Boone County Health Center to: (Check One for Information to be Released or Requested)

_____ Release Information To: OR _____ Obtain Records From:

Facility/Provider/Name_____ Phone #_____

Address_____ Fax #_____

City/St/Zip_____ Email_____

**Purpose of Disclosure (Check One)**

____ Patient Request ____Other

**Date(s) of Service to be Disclosed (Check One)** (copy fees may apply in accordance with Nebraska law)

____ _____to_____ (insert date range) ____All Dates of Service

**Health Information to be Disclosed (Check all that apply)**

____All ____Clinic Notes ____Laboratory ____Cardiac (Specify)
____Immunizations
____Therapy OT, PT, ST ____Hospital Notes ____Radiology ____Operative Record
____Other (Specify)_____

***I specifically Authorize the release of Information relating to:*** **Please initial each you authorize.**

**____ Substance Abuse ____ Mental Health ____ HIV/AIDS related information**

**Format for Disclosure: (Check One)**

____ Paper Copies ____ Fax ____ CD ____ Encrypted Email ____ Other (if feasible)
_____

**I understand and acknowledge that:**

*My refusal to sign this authorization will not affect my ability to obtain treatment at BCHC.

*Medical information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
*This authorization is effective for twelve (12) months from the date of signature. I understand that I may revoke this authorization at any time by giving written notice to BCHC's Heath Information Management (HIM) Department. My revocation will not be effective to the extent of action that has already been taken in reliance on my authorization.
*I have read (or had read to me) and have received a copy of this document.

**Signature**: _____ Relationship to Patient: _____ Date: _____

**Signature of Witness (Employee):** Must attach **photocopy ID** for person responsible for picking up records: _____