AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Sarpy County OB-GYN, P.C. 1413 S. Washington St Suite 270 Papillion NE 68046 Phone 402-898-8500 Fax 402-898-8510

I hereby authorize_____
(Name of Provider)

_____
(Address) (City) (State) (Zip Code)

to disclose the following information from the PHI of:

Patient name: _____Date of Birth_____
(Last) (First) (M/I) (Month/Day/Year)

Address:_____City/State_____ Zip Code_____

Covering the period(s) of health care from_____ to _____

INFORMATION TO BE DISCLOSED

___Complete Health Record
___Consultation Reports
___Laboratory Reports
___X-Ray Reports
___Miscellaneous Test Results/Reports
___Other (specify)_____
___Discharge Summary
___History & Physical
___Office Visits
___Echo Video/X-Ray Films

I understand that this will include information relating to (check if applicable)
___Acquire immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
___Behavioral health services/psychiatric care
___Treatment for alcohol and/or drug abuse

This PHI is to be disclosed to:

Name of provider, person, facility or institution:_____

_____
(Address) (City) (State) (Zip Code)

_____ _____
(Telephone) (Fax)

for the purpose of_____
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 180 days from the date of signature.

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. This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically permitted by appropriate state or federal law.

Signed:_____ Dated:_____
(Patient) (Month/Day/Year)

_____ _____ Date:_____
(or legal representative) (relationship to patient) (Month/Day/Year)