Primary Care Partners

3201 Pioneers Blvd. Ste 304 Lincoln, Ne. /4130 Pioneer Woods Dr. Ste 2 T: 402-483-2987 F: 402-483-2980

Authorization to Use or Disclose Health Information

Patient name: _____ Date of birth:_____

Patient address: _____

I. <u>My Authorization</u>: You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by the practice

☐ My health information for the date(s):_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Please send records to:

Facility/Physician_____
Street address:_____
City/State/Zip:_____
Phone/Fax:_____

Please retrieve records from:

Facility/Physician_____
Street address:_____
City/State/Zip:_____
Phone/Fax:_____

Reason(s) for this authorization: _____

This authorization ends*: This authorization shall expire upon the earlier of _____ or one year from the date of this authorization, except that any authorization to release medical records hereunder shall expire no later than **180 days** from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you as required by law.

II. <u>My Rights</u>

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

- To take part in a research study;

  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing, by certified mail. Mail to: Primary Care Partners, Attn. Office Manager, 3201 Pioneers Blvd. Ste 304, Lincoln Ne. 68502. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once we receive your revocation request, we will immediately stop using and disclosing the health information in this authorization form. Your revocation shall not apply to those uses and disclosures we made on behalf pursuant to this authorization prior to the time we received your written revocation.

Once the office discloses health information, the person or organization that receives it may be able to re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

*Note: If signed by someone other than the patient, we need written proof of your authority.

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