



Quality Healthcare Clinic
301 S. Way
P.O. Box 486
Sutton, NE 68979
Phone (402) 773-0115
Fax (402) 773-0119

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name _____ Date of Birth _____

I hereby authorize Quality Healthcare Clinic (301 South Way, PO Box 489, Sutton, NE 68979)

To: Disclose to Obtain from

Organization or Individual _____

Street Address _____

City and State _____

Dates of Treatment _____

Fax Number _____

Information to be Disclosed:

- | | | |
|--|--|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> Office Notes | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Complete Record | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Financial Record |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray | <input type="checkbox"/> Radiology Films: |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Lab | <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Other
(Specify) _____ | | <input type="checkbox"/> Mammogram <input type="checkbox"/> Nuclear Medicine |

Purpose for which information is to be used:

- Treatment Insurance/Payers Personal
 Legal Proceedings Other (Specify) _____

If records are requested to be given directly to me, I understand that payment is due at signing before they are copied.

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

I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to this authorization. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless previously revoked this authorization will automatically expire six (6) months from date of signature. I consider a photocopy of this authorization to be as valid as the original.

I understand that authorizing the disclosure of protected health information is voluntary and that I can refuse to sign this authorization. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules.

Signature of Patient or Legal Representative

Date

Signature of Witness

If signed by Legal Representative, state Relationship to Patient