

DATE RECEIVED: _____

AUTHORIZATION EXPIRATION DATE: _____

DATE STARTED: _____

(see last paragraph below)

TO: Sarah Bush Lincoln Health Center Lincolnland Home Care Lincolnland Home Medical Equipment
 Physician Clinic: _____ Lincolnland Hospice Other: _____
 SBL Dental Services

You are hereby authorized to release protected health information to: *(Who the protected health information is going to)*

 (Name of Party to Receive Protected Health Information)

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

Release protected health information of: _____
 (Name of Patient) (Birthdate xx / xx / xxxx)

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

The patient or authorized representative authorizes the use or disclosure of protected health information to be released. **Patient or authorized representative must initial the item, which needs additional protected health information disclosed.**

___ Mental Health/Psychiatric ___ Psychotherapy Notes ___ Alcohol and/or Drug Related ___ Genetic Testing
 ___ Abuse ___ HIV/AIDS ___ Other Communicable Disease ___ Women's Health Care

Date of Care: _____ Medical Record #: _____ Encounter #: _____

The Type of protected health information to be used or disclosed is as follows:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Diagnosis / Procedures | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Delivery Tickets |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Registration Sheet | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> X-ray Films | <input type="checkbox"/> Pick up Tickets |
| <input type="checkbox"/> Report of Operation | <input type="checkbox"/> Pertinent Data | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Service Reports |
| <input type="checkbox"/> Provider Progress Notes | <input type="checkbox"/> Entire Admission | <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Certificates of Medical Necessity | |
| <input type="checkbox"/> Other (Specify) _____ | | | | |

Method of release: Photocopies Verbal FAX CD Film

For the purpose of: Continued Treatment Evidence of Care Legal

The foregoing authorization was read, discussed, and signed in my presence. I am signing freely and with full knowledge and understanding. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that other health care provider records may be a part of my hospital record and I can release them as authorized. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by the Federal Health Information Privacy Regulations. The redisclosure of drug and alcohol abuse is generally prohibited in accordance with the confidentiality of alcohol and drug abuse patient record rules. I understand that I can contact these departments for questions about disclosures of my protected health information.

I further understand that a refusal to authorize the release of the above information will prevent the disclosure of the information without further authorization or when mandated by law. There is the right to revoke the authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insured with the right to contest a claim under my policy. **Unless otherwise revoked in writing, this authorization will expire 1 year from date signed.**

Signed _____ Date _____ Time _____
 (Patient or Legal Representative)

If Legal Representative, document relationship to Patient: _____

Signed _____ Date _____ Time _____
 (Witness)

Processed By: _____ Date: _____ Number of pages: _____

