Elkhorn Valley Family Medicine

Authorization To Disclose Health Information

Patient Name: _____
Date of Birth: _____
Address: _____

1. I authorize the use or disclosure of the above named individual's heath information to:

   Elkhorn Valley Family Medicine
   304 East Douglas Street
   O'Neill, NE 68763
   Ph: 402-336-4222 Fax: 402-336-4228

2. The following individual(s) or organizations is authorized to make the disclosure:
   Name: _____
   Address: _____

3. The information to be disclosed is (check all that apply):
   _____ Complete medical record
   _____ Summary record (includes discharge summaries, history and physicals, consultation reports, operative notes, radiology reports, pathology reports, emergency department notes, and most recent 12 months of laboratory reports)
   _____ Electronic medical records
   Dates _____ to _____
   _____ Other _____

4. I understand the information in my health record may include information relating to sexually transmitted diseases, behavioral or mental health services, treatment for alcohol/drug abuse, and infectious diseases including tuberculosis (TB), acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must present a written revocation. I understand the revocation will not apply to information that has already been released in response to this authorization. I also understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. I understand I need not sign this form in order to ensure healthcare treatment, payment, or enrollment in my health plan/eligibility for benefits.

Signature of Patient: _____ Date: _____/_____/_____

Signature of Legal Representative
of Patient and Relationship to Patient: _____
Relationship: _____
Signature of Witness: _____