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:

[ ] Face Sheet
[ ] Consultation Report
[ ] History and Physical Exam
[ ] Discharge Summary
[ ] Operative Report
[ ] Other
(Specify)_____

[ ] Office Notes
[ ] Complete Record
[ ] Emergency Room Record
[ ] X-ray
[ ] Lab

[ ] Pathology Report
[ ] Verbal Communication
[ ] Financial Record
[ ] Radiology Films:

[ ] CT [ ] MRI [ ] Ultrasound
[ ] Mammogram [ ] 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