PLATTE VALLEY CLINIC

NORTH PLATTE VALLEY MEDICAL CENTER

Authorization to Use and Disclose Medical Records

Patient's full name: _____ Date of Birth:_____
Social Security No: _____

I, the above named, authorize Platte Valley Clinic **or** North Platte Valley Medical Center to release information to:

Name (First Last): _____
Address, City, State: _____
Phone Number: _____Fax:_____

For the purpose of:

_____ Continued Medical Care
_____ Insurance Claim Processing
_____ Legal Claim processing
_____ Other

By initialing or marking the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records:

_____ Please send entire medical record

_____ Discharge Summary Dates: _____
_____ H&P Dates: _____
_____ Consultation Reporting Dates: _____
_____ Medication Listing Dates: _____
_____ ER Record Dates: _____
_____ Operative Record Dates: _____
_____ Lab/pathology Reports Dates: _____
_____ Radiology Reports Dates: _____
_____ Radiology Films Dates: _____
_____ Other Dates: _____

The following items must be initialed to be included in the use and/or disclosure of other health information:

_____ HIV/AIDS related information and/or records
_____ Mental Health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment, or referral information

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recent may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may revoke this authorization at any time, provided I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing unless otherwise specified below.

Valid until one year of date of signing unless otherwise stated here: _____

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Patient Name

_____ _____
Printed name of legal representative (if applicable) Relationship to patient