north platte obgyn

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

There is a records fee. Please contact the office at 308-534-4804 for details.

I_____ voluntarily authorize the disclosure of information from my record.

The purpose for this disclosure is:_____.

Date of Birth_____ Previous Name _____ Phone #_____

Address_____

Information to be disclosed by:

Name of Facility **North Platte OB/GYN, PC**

Address **1115 South Willow Street**

City/State/Zip **North Platte, NE 69101**

Phone **308-534-4804**

Fax **308-534-0460**

Information to be provided to:

Name of Facility/Person_____

Address_____

City/State/Zip_____

Phone_____

Fax_____

The information to be disclosed from my health record (please check appropriate line):

- ○ Entire Record
- ○ Obstetrical Record
- ○ Only information related to _____
- ○ Only information from date of service _____

If you would like any of the following sensitive information disclosed, check the boxes below:

- ○ Alcohol/Drug Abuse Treatment/Referral
- ○ Sexually Transmitted Diseases
- ○ HIV/AIDS Related Status and Treatment
- ○ Mental Health

I understand that I may revoke this authorization in writing submitted at any time, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under this policy.
If the authorization has not been revoked, it will terminate one year from the date of my signature or on the following date:_____

Signature of Patient:_____ Date:_____

Signature of Authorized Representative (state relationship to patient)

_____ Date: _____

My signature above released the facility, physicians, and its employees from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herin. _____ ***(please initial here)***