

If requesting your protected health information for release to another party (i.e. attorney, caregiver, life insurance) complete the next two pages and mail to:

Health Information Department
Saint Francis Medical Center
2620 West Faidley Ave., P.O. Box 9804
Grand Island, NE 68802-9804

If you have questions please call the Health Information Department at 308-398-5658

SAINT FRANCIS MEDICAL CENTER
2620 West Faidley Ave, Box 9804
Grand Island, Ne. 68802-9804, 308/398-5658

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____

Medical Record#: _____

I, _____, (individuals name) authorize Saint Francis Medical Center to disclose my individually identifiable health information as described below to the following person(s) or organization:

Receiving facility/person or organization

Street Address	City, State, and Zip Code	
The following individually identifiable health information may be disclosed:		
<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Diagnostic Reports	<input type="checkbox"/> Emergency Room Report
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnostic Films	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Physician Orders/Progress Notes	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Psychological/CD Eval
<input type="checkbox"/> History and Physical Records	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> OP Clinic Notes
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Electronic medium	<input type="checkbox"/> Treatment/Aftercare
<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Verbal release	<input type="checkbox"/> Photograph (not for
<input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Residential Summary of Care	media)

Dates of treatment to be released:

Reason/purpose/event for the use and/or disclosure of the information:

Expiration:

This authorization will expire twelve months from signature date of this authorization, or will expire once the need for information is met for the specified event, and will cause the authorization to expire.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Prohibition on Conditioning of Authorization: Saint Francis Medical Center will not condition treatment on your signing this authorization, unless:

- * You are receiving research-related treatment; or
- * The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

