Authorization To Use, Disclose & Access Protected Health Information

Patient Name: _____ MR#_____

Address: _____

Date of Birth: _____ Phone #: _____

I hereby authorize: (please check all that apply)

☐ **Brodstone Healthcare**
520 East 10th Street
Superior, NE 68978
Phone: 402-879-3281
Fax: 402-879-3332

☐ **Brodstone Family Medical Center - Superior**
525 East 11th Street
Superior, NE 68978
Phone: 402-879-4781
Fax: 402-879-3365

☐ **Brodstone Family Medical Center - Nelson**
76 West 8th Street
Nelson, NE 68961
Phone: 402-225-2375
Fax: 402-225-2084

☐ **Brodstone Family Medical Center - Edgar**
315 North C Street
Edgar, NE 68935
Phone: 402-224-3344
Fax: 402-224-3099

to: ☐ Obtain From: ☐ Release To: ☐ Allow Access To:

Organization or Individual: _____

Phone Number: _____ Fax Number: _____

Relationship to Patient: _____

Street Address: _____

City and State: _____

Dates of Treatment: _____

Information to be disclosed:

☐ History & Physical Exam	☐ Consultation Reports	☐ Financial Record
☐ Progress Notes	☐ Emergency Room Records	☐ Complete Record
☐ Lab Reports	☐ Discharge Summary	☐ Thrive Center Records
☐ Radiology Reports	☐ After Care Plan	☐ Other: _____

I specifically authorize the release of information relating to:

☐ Substance abuse (including alcohol/drug abuse)
☐ Mental Health
☐ HIV/AIDS related information (including test results)

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Brodstone Memorial Hospital, or Superior, Nelson, or Edgar Family Medical Centers.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to BMH or SFMC. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient, if signed by Legal Representative

Internal Use Only
_____ _____
Originated Completed