CHADRON MEDICAL CLINIC, PC
PO BOX 431
CHADRON, NE 69337
PH: 308-432-4441 FAX: 308-432-2130

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Request Records From:	**Send Records To:**
Facility Name ____________	Facility Name ____________
Physician's Name____________	Physician's Name____________
Address ____________	Address ____________
City, State ____________	City, State ____________
Phone ____________	Phone ____________
Fax____________	Fax____________

Patient Name:____________ Date of Birth:____________

Address: ____________ SSN:____________

City, State____________ Phone:____________

Information to be released: From Dates:____________

_____Complete Health Record(s) _____Discharge Summary
_____History and Physical exam _____Progress Note(s)
_____Consultation Reports _____Laboratory Tests
_____X-ray Reports _____Other____________

I understand that this will include information relating to (check if applicable):

_____AIDS or HIV For dates from ____________ to present
_____Alcohol/drug abuse treatment For dates from ____________ to present

Purpose of disclosure:

_____Changing Physicians _____Second Opinion _____Continuing Care
_____Legal _____At my (patient) request _____Insurance
_____Worker's Comp _____School _____Other____________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the 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 I specify differently, this authorization will expire ________ not greater than 180 days. If I fail to specify an expiration date, this authorization will expire 180 days from the date it is signed.

I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Release authorized by:____________
(Print Name) (relationship)

Signature:____________ Date:____________