GOTHENBURG HEALTH
Well Ahead

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME_____ **D.O.B.** _____/_____/_____

ADDRESS_____ **CITY** _____ **STATE** _____

ZIP CODE _____ **PHONE**_____

- ***I hereby authorize Gothenburg Health to use and/or disclose my health information as follows:***

DISCLOSE TO ☐ / OBTAIN FROM ☐: _____
Recipient Name

_____
Address **Phone/Fax Number**

PURPOSE(S) OF DISCLOSURE: _____

INFORMATION TO BE DISCLOSED/OBTAINED FROM:

☐ Complete Record	☐ Emergency Room Record
☐ Progress / Office Notes	☐ Discharge Report
☐ Lab Reports	☐ After Care Plan
☐ X-Ray Reports	☐ Financial Record
☐ History and Physical Examination	☐ Consultation Report

I specifically authorize the release of information relating to:

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

DATES OF SERVICE TO BE DISCLOSED/OBTAINED FROM: (Time period or "All") _____

PREFERRED METHOD OF DELIVERY: ☐ USPS ☐ Pick Up at hospital ☐ Email ☐ CD ☐ Other_____

Email**:** _____

***I understand and acknowledge that*:**

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Gothenburg Health.

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 unless otherwise stipulated. I understand that I may revoke this authorization at any time by giving written notice to Health Information Management (HIM) or the HIPAA Privacy Officer at the hospital. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

4. I have read (or had read to me) and have received a copy of this document. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative **Date**

Relationship to patient if signed by personal representative_____

PO Box 469 / 910 20th Street
Gothenburg, NE 69138
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