LINCOLN OB-GYN, P.C

Authorization to Release Protected Health Information

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). By signing this authorization, I understand Lincoln OB-GYN, P.C. is authorized to use and/or disclose my protected health information as specified herein. This authorization may expand, but not limit the use and/or disclosure to/from Lincoln OB-GYN, P.C. for purposes of treatment, payment or health care operations.

By signing below, you acknowledge receipt of a signed copy of this authorization.

Signed by: ________________________________ ______________________ _____________

Signature of Patient or Legal Guardian   Relationship to Patient   Date

____ ______________________________________

Printed Name of Patient   Printed Name of Legal Guardian

_________________________________ _________________________ __________________

Patient's Address   Social Security Number   Date of Birth

*****Note: If signed by someone other than the patient we need written proof of your authority. *****

I authorize the release of my Protected Health Information between the entities listed:

TO / FROM (circle):

Lincoln OB-GYN, P.C.
9110 Andermatt Drive, Suite #2, Lincoln, NE 68526-9639
Phone # (402) 483-7641 Fax # (402) 483-0527

TO / FROM (circle): Include full name with address, phone and fax numbers

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Check the description of the information to be disclosed:

___ Complete medical record or,

___ Medical records from ____________ to _____________ or,
(Date) (Date)

___ Specific medical records as listed: ______________________________.

State the purpose or need for which the information is to be used by the individual to whom information is to be released (i.e. personal, legal, benefits, state reporting, research, or other).____.

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I understand that when the information is used or disclosed because of this authorization, my protected health information may be subject to re-disclosure by the recipient. We will not have the ability to monitor whether your health information may be further used or disclosed by such parties and may no longer be protected health information. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws. In addition, I understand that disclosures pursuant to this authorization are not subject to HIPAA accounting rules.
We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, you failure to sign this authorization will prevent us from providing such treatment.

This authorization will expire on _____________________.
Expiration Date
If no date is written, the Authorization shall expire twelve months from the date of signature on this form.

I specifically authorize the release of data and information relating to, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable line):_________HIV (AIDS virus), _________sexually transmitted diseases, __________mental health, or _________drug and/or alcohol abuse.
I understand that I or my legal representative retains the right to revoke this authorization. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation. To revoke this authorization, I/We must submit in writing the following:

- Patient’s name
- Effective date of the authorization
- Recipients of protected health information
- Patient’s desire to revoke this authorization
- Date of the revocation, and the patient or legal guardian’s signature

All revocations must be sent to the Privacy Officer at Lincoln OB-GYN, P.C., 9110 Andermatt Drive, Suite #2, Lincoln, NE 68526-9639
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I fully understand and accept the terms of this authorization.

FOR OFFICE USE ONLY
Authorization verified by _______________________________ on ________________.

Authorization added to the patient’s medical record Log on _______________________.

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