Medical Record #______________

AUTHORIZATION TO RELEASE HEALTH INFORMATION
PENDER COMMUNITY HOSPITAL & PENDER MEDICAL CLINIC

100 Valley View Drive, Pender, NE 68047
Phone: 402-385-3033 Fax:712-222-7846

I hereby authorize [name of provider] ____
to disclose the following information from the health records of:

PATIENT NAME________________________________ Date of Birth________________
Address ____________________________________
____

Covering the period(s) of healthcare: From (date)______________________ to (date)______________________

Information to be disclosed (check all that apply):

________Complete Health Record(s)
________Face Sheet
________Outpatient Form
________Outpatient Notes
________Discharge Summary
________History & Physical
________Consultations
________Laboratory Tests
________X-ray Reports
________EKG's
____
________Other______________________

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

_______Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
_______Behavioral health services / psychiatric care
_______Treatment for alcohol and / or drug abuse

This information to be disclosed to:
____
____
____

For the purpose of:
____
____
____

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 60 days from date of signing. A request received after the expiration date or a request received after revocation of the authorization shall not be honored.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further is expressly permitted by 42 CFR Part 2. A general authorization for the release of the medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Source: 42 CFR §2.31 & §2.32 (October 1, 1997 ed).

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed____ Date________________________
(patient)

____
or (legal representative) (relationship to patient) (date)

____
(signature of witness) (relationship to patient) (date)