AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT FULL NAME____

PHONE NUMBER_______________________ BIRTHDATE__________________

ADDRESS____

□ **I** hereby authorize Lincoln County Health Department to disclose PHI concerning the above-named person to ___________________________________.

□ **I** hereby authorize ___________________________________ to disclose PHI concerning the above-named person to Lincoln County Health Department.

For the following purpose: ____.

Information to be disclosed is: (write specific information you want to be shared)

This authorization shall remain in effect until ___________ (date) or __________ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of the at information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be redisclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form, unless my treatment includes research, or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulations, and that I may get a copy of this form after I sign it.

I understand that I can revoke this authorization in writing but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, I should contact: Lincoln County Health Department, 114 W. Court, Lincoln 67455. 785-524-4406

____ ______________

Signature of Patient or Patient Personal Representative Date

114 West Court Street, PO Box 187 Lincoln, Kansas 67455
Phone: 785-524-4406 Fax: 785-524-5003 E-mail: lchd@att.net
www.lincolncoks.com