Authorization to Use or Disclose Protected Health Information

PRAIRIE STAR Health Center

I hereby authorize the use or disclosure of my individually identifiable health information. I understand that this authorization is voluntary. I understand that once information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

PATIENT INFORMATION			
LAST NAME	FIRST		MIDDLE
ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE	WORK PHONE		DATE OF BIRTH

PERSON(S) OR FACILITY TO *SEND* INFORMATION			PERSON(S) OR FACILITY TO *RECEIVE* INFORMATION		
NAME			NAME		
ADDRESS			ADDRESS		
CITY	ST	ZIP	CITY	ST	ZIP
FAX	PHONE		FAX	PHONE	

THIS INFORMATION WILL BE USED FOR:

- ☐ **my personal records**
- ☐ **sharing with other health care providers (as needed)**
- ☐ **other (please describe):**

INFORMATION TO BE DISCLOSED

DOCUMENTS	CHECK IF REQUESTED	TREATMENT DATE(S)	SENDER TO CHECK IF UNAVAILABLE	CHECK ONCE RECEIVED BY PSHC
Demographics	☐			
Office Notes	☐			
Hospital/ER Records	☐			
Surgery/Op Notes	☐			
Immunization Records	☐			
Lab/Path/Micro	☐			
Diagnostics/Radiology	☐			
Entire Inside Record	☐			
Entire Outside Record	☐			
PAP Smear and HPV	☐			
Mammogram	☐			
Colonoscopy	☐			
Other:	☐			

***Inside = items generated by in-house practitioners**
Outside = items generated by outside practitioners, in-house practitioners cannot be responsible for accuracy or completeness.

The information disclosed may include matters regarding mental health, alcohol or drug abuse and infectious diseases, including AIDS or HIV test results. Such information may be subject to special protections. If you do not wish such information to be released, list information to be excluded here:

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if do, it will not have any affect on any actions taken before the revocation was received. Unless revoked, this authorization expires 1 year from the date signed below unless otherwise requested here:

I have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.

A faxed or photocopy of this authorization shall be considered valid. I give permission for this information to be faxed if necessary.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, PLEASE STATE RELATIONSHIP TO PATIENT	