If requesting your protected health information for release to another party (i.e. attorney, caregiver, life insurance) complete the next two pages and mail to:

Health Information Department
Saint Francis Medical Center
2620 West Faidley Ave., P.O. Box 9804
Grand Island, NE 68802-9804

If you have questions please call the Health Information Department at 308-398-5658.

SAINT FRANCIS MEDICAL CENTER
2620 West Faidley Ave, PO Box 9804
Grand Island, NE 68802-9804, 308/398-5658

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____
Medical Record#:_____

I, _____, (individuals name) authorize Saint Francis Medical Center to disclose my individually identifiable health information as described below to the following person(s) or organization:

_____
Receiving facility/person or organization

_____
Street Address City, State, and Zip Code

The following individually identifiable health information may be disclosed:

__Face Sheet __Diagnostic Reports __Emergency Room Report
__Discharge Summary __Diagnostic Films __Immunization Record
__Physician Orders __Operative Report __Psychological/CD Eval
Progress Notes __Pathology Report __OP Clinic Notes
__History and Physical __Electronic medium __Treatment/Aftercare
Records
__Consultation Reports __Verbal release __Photograph (not for media)
__Physical Therapy Notes __Residential Summary of Care
__Other (please specify) _____

Dates of treatment to be released:
_____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:
_____

Prohibition on Conditioning of Authorization: Saint Francis Medical Center will not condition treatment on your signing this authorization, unless:
* You are receiving research-related treatment; or * The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire automatically after 180 days from date of signature or upon satisfaction of the need for disclosure as specified.

Revocation: I understand that I may revoke this authorization at any time by notifying Saint Francis Medical Center in writing by sending a letter to Saint Francis Medical Center, Health Information Department, 2620 W. Faidley Ave, P.O.Box 9804, Grand Island, NE 68802-9804 or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that Saint Francis Medical Center took before it received my revocation letter. For example, Saint Francis Medical Center cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the Saint Francis Medical Center's Notice of Privacy Practices.

_____ _____
SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

_____
Printed name of individual's personal representative, if applicable: (e.g., parent, legal guardian):

_____

- -

FOR INTERNAL PURPOSES ONLY

When Saint Francis Medical Center is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel: _____

Received by: _____

Date: _____

_____ Signed copy of authorization provided to the individual

MR#31