Franklin County Memorial Hospital (HIPPA)
1406 Q Street, Franklin, NE 68939 (Phone) 308-425-6221 (Fax) 308-425-3164

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ D.O.B. _____
ADDRESS: _____ PHONE: _____

Also known as: _____

I hereby authorize **FCMH/Pool Medical Clinic/ Main Street Clinic** to use/or disclose my health information as follows:

OBTAIN FROM:

_____ _____ _____
Facility/Person Phone # Fax #

ADDRESS: _____ CITY_____ STATE_____ ZIP_____

PURPOSE(S) OF DISCLOSURE: _____

☐ Check this box is disclosure is at the request of the individual
☐ Continue Care
☐ Other _____

INFORMATION TO BE DISCLOSED:

☐ History and Physical examination
☐ Progress Notes
☐ Lab Reports
☐ X-ray Reports/Film
☐ Consultation Report
☐ Emergency room record
☐ Discharge Report
☐ After Care Plan
☐ Financial Record
☐ Complete Record

I specifically authorize the release of information related to

☐ *Substance abuse (including alcohol/drug abuse)*
☐ *Mental Health*
☐ *HIV/AIDS related information (including test results)*

DATES OF SERVICE OR TIME OF RECORDS TO BE DISCLOSED: _____
(State Time Period or "all")

DISCLOSE TO:

_____ _____ _____
Facility/Person Phone # Fax #

_____ _____ _____ _____
Address: City State Zip

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at FCMH and clinics.
2. Medical Information to be disclosed pursuant to his authorization may be subject to re-disclose by the recipient no longer protected by state or federal law.
3. This authorization is effective for TWELVE months after date it was signed. I understand that I may revoke this authorization at any time by giving written notice to PRIVACY OFFICER OR HIM DEPARTMENT. My revocation will not be effective to the extent action has already been taken to release on my authorization.
4. I have read (or had read to me) and received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Printed Name of patient or patient's personal representative Date

_____
Signature of patient or patient's personal representative

_____ _____
Relationship to patient if signed by personal representative Witness

Revised July, 2022