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 _____ DATE OF BIRTH _____
ADDRESS _____ PHONE _____
Also Known As: _____

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

OBTAIN FROM:

_____ _____ _____
Facility/ Person Phone Number Fax Number

ADDRESS: _____ CITY _____ STATE ____ ZIP _____

PURPOSE(S) OF DISCLOSURE: _____

- ☐ Check this box if 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/Films
- ☐ Consultation Report
- ☐ Emergency Room Record
- ☐ Discharge Report
- ☐ After Care Plan
- ☐ Financial Record
- ☐ Complete Record
- ☐ Substance Abuse (incl Drug/Alcohol abuse)
- ☐ Mental Health
- ☐ HIV/AIDS related info (incl test results)
- ☐ Release All Records
- ☐ Specific Time Period

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED: _____ (Date) to _____ (Date)

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 this authorization may be subject to re-disclosure 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 forces and effect as the original

_____ _____
Signature of Patient or Patient's Personal Representative Date

_____ _____
Relationship to Patient if Signed by Personal Representative Witness

Revised: July 9, 2018
Retyped: February 25, 2020 HLG