WINNEBAGO COMPREHENSIVE HEALTHCARE SYSTEM
P.O. Box HH | 225 S Bluff Street | Winnebago, NE | 402-745-3950

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. DISCLOSURE

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Patient Legal Name)

II. DISCLOSURE INFORMATION

This information is to be DISCLOSED BY: *(select one)*

☐ Winnebago Comprehensive Healthcare System ("WCHS")

☐ _____ , _____
(Name of Individual/Entity) *(Street Address)* *(City)* *(State)* *(Zip)* *(Phone)*

This information is to be PROVIDED TO: *(select one)*

☐ Winnebago Comprehensive Healthcare System ("WCHS")

☐ _____ , _____
(Name of Individual/Entity) *(Street Address)* *(City)* *(State)* *(Zip)* *(Phone)*

☐ Patient ☐ Parent, Guardian, or Legal Representative as listed: _____

☐ Class of Persons *(specify, eg. any provider who has provided treatment to me)*: _____

III. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Treatment, Payment, or Other Healthcare Operations ☐ Attorney ☐ School ☐ Personal Use ☐ Disability ☐ Research ☐ Marketing***

☐ Other *(specify)*: _____

IV. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD *(check appropriate box[es])*:

☐ Immunizations ☐ Facesheet ☐ Most Recent Annual Wellness Exam ☐ Health Summary Report ☐ Labs Only ☐ Entire Record

☐ Only the period of events from _____ to _____

☐ Only the information related to *(specify condition/treatment)*: _____

☐ Other *(specify) (PRC, billing, etc.)*: _____

If you like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Substance Abuse Disorder Treatment ☐ HIV/AIDS-related Treatment ☐ Mental Health *(excludes Psychotherapy Notes)*

☐ Sexually Transmitted Infections ☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

V. AUTHORIZATION

I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one (1) year from the date of my signature unless a different expiration date or expiration event is stated. _____
[specify date (mm/dd/yyyy)]

I understand that WCHS will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]

SPECIFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS: *I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations..*

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(state relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(if signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

PATIENT IDENTIFICATION AND VERIFICATION - TO BE COMPLETED BY WCHS STAFF ONLY

☐ Identification Card/Drivers License	NAME *(Last, First, MI)*:
☐ Other Photo Identification	RECORD NUMBER:
Verification Completed By *(initials)*:	DATE OF BIRTH:
ROI Processed by *(initials)*:	ROI Processed Date:

*****Fill this out *ONLY IF* this protected health information is being used or disclosed for marketing purposes:**

☐ WCHS *IS* receiving something of value (eg. money, products, services, etc.) by disclosing the requested information.

☐ WCHS *IS NOT* receiving something of value by disclosing the requested information.