## 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**

| l,(Patient Legal Name)   |  | , hereby voluntarily autho  | rize the disclosu  | are of info  | rmation from my health record  |
|--|--|---|--|--|--|
|  |  |   |  |  |  |
| II. DISCLOSURE INFORMATION   | -1   |   |  |  |  |
| This information is to be <u>DISCLOSED BY:</u> (select one ☐ Winnebago Comprehensive Healthcare Syste  |  |   |  |  |  |
| - ,  | eni ( wcns )   |   |  |  |  |
| (Name of Individual/Entity)  | (Street Address)   | (City)  | (State)  | (Zip)  | (Phone)  |
| This information is to be <b>PROVIDED TO</b> : (select one   | <del>?</del> )   |   |  |  |  |
| ☐ Winnebago Comprehensive Healthcare Syste   | em ("WCHS")  |   |  |  |  |
| ☐(Name of Individual/Entity)   |  | (Cit.)  | (6)  | (7:-)  | (0)  |
|  |  | (City)  | (State)  | (Zip)  | (Phone)  |
| ☐ Patient ☐ Parent, Guardian, or Legal Repr  |  |   |  |  |  |
| ☐ Class of Persons (specify, eg. any provider who  | nas proviaea treatment to  | пе):  |  |  |  |
| II. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:  | :  |   |  |  |  |
| ☐ Treatment, Payment, or Other Healthcare Op   | erations 🗌 Attorney 🗍  | School  Personal Use  | ☐ Disability ☐   | Research   | □ Marketing***   |
| Other (specify):   |  |   |  |  |  |
|  |  |   |  |  |  |
| V. THE INFORMATION TO BE DISCLOSED FROM MY I   | HEALTH RECORD (check a   | ppropriate box[es]):  |  |  |  |
| ☐ Immunizations ☐ Facesheet ☐ Most Rec   | cent Annual Wellness Exan  | n ☐ Health Summary Rep  | oort 🗌 Labs Onl  | y 🗌 Entire   | e Record   |
| Only the period of events from   |  |   |  |  |  |
| ☐ Only the information related to (specify condition   | tion/treatment):   |   |  |  |  |
| ☐ Other (specify) (PRC, billing, etc.):  |  |   |  |  |  |
| If you like any of the following sensitive infor   |  |   |  |  |  |
| Substance Abuse Disorder Treatment   |  |   | -  |  |  |
| ☐ Sexually Transmitted Infections ☐  | Psychotherapy Notes O  | NLY (by checking this box, I  | am waiving any p   | osychother   | apist-patient privilege)   |
| /. AUTHORIZATION   |  |   |  |  |  |
|  |  |   |  |  |  |
| I understand that I may revoke this authorization in w   |  | [45 CFR Part 164], and  | the Privacy Act  | of 1974 [5   | USC 552a]  |
| time to the Health Information Management Departn  | nent, except to the  |   | •  |  | USC 552a]  |
| time to the Health Information Management Department that action has been taken in reliance on this a  | nent, except to the authorization. If this   | SPECIFIC PROVISIONS   | REGARDING THE  | USE OR D   |  |
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Date: 2024-11-21 1 Ver. No. 1.0

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

☐ WCHS <u>IS NOT</u> receiving something of value by disclosing the requested information.