Forward Family Healthcare

AUTHORIZATION TO *OBTAIN* HEALTH INFORMATION

1. _____ _____
Name of Patient **Birth Date**

_____ _____
Street Address **City, State, Zip**

2. **AUTHORIZES**:_____

3. ***TO OBTAIN*** **PROTECTED HEALTH INFORMATION FROM:**

_____
Name of Health Care Provider/Plan/

_____
Street Address

_____
City, State, Zip Code

1. **INFORMATION TO BE OBTAINED:**

□ Discharge Summary
□ History & Physical
□ X-Ray Reports
□ Consultations
□ Physician Progress Notes
□ List of Allergies
□ Physician Orderrs
□ Lab Results
□ Medication Lists
□ Problem List
□ Immunization Records
□ Other:
_____
□ Entire Record

For the following dates: _____

In compliance with the Nebraska Mental Health Procedures Act:
___ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.
___ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

_____

5. **PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)**

___ Further Medical Care
___ Insurance Eligibility/Benefits
___ Legal Investigation or Action
___ Personal
___ Changing Physicians
___ Other (Specify): _____

6. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights with Respect to This Authorization:

- **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.
- **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. This consent can be revoked, however the request must be in writing. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following dates:

_____

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

9. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

10. **Signature of Patient: _____ Date: _____**

(If signed by person other than patient, state relationship and authority to do so.)

Patient is: _____ Minor _____ Incompetent _____ Disabled _____Deceased

Legal Authority: _____Custodial Parent _____Legal Guardian

_____Executor of Estate of Deceased _____Power of Attorney for Healthcare

_____Authorized Legal Representative

Signature of Witness: _____ Date: _____