

**Family Practice of Grand Island, PC** 12/12/05

2116 W Faidley Ave, Ste 400  
Grand Island, NE 68803  
Phone 308-381-0162 Fax 308-389-4445

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)**

(Please complete in ink. Attach copy of ID for verification.)

Patient Name \_\_\_\_\_ Previous Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Acct # \_\_\_\_\_

I give written authorization for  verbal &/or  written PHI disclosure on the patient named above:

FROM: (CLINIC/MD) \_\_\_\_\_ TO: \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_ Fax# \_\_\_\_\_  
DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Disclosure Purpose:  Transfer of PHI  Marketing (non face to face)  Legal  
 Insurance applications  Employment Determinations  Research  
 Other \_\_\_\_\_

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law. This authorization applies to:

Complete PHI (medical record)  
 PHI relating to the following condition(s), test(s) or date(s) of treatment: \_\_\_\_\_  
 Other \_\_\_\_\_

**If the PHI release that I have authorized directly above includes any of the following *highly protected health information*, I give specific authorization to release this highly protected health information for which I may have been tested, diagnosed or treated. (Please initial each as applicable.)**

**Drug use, Alcohol use, Substance Abuse**  **HIV, AIDS**  
 **Mental health** (Psychotherapy notes prohibited by law)  **Sexually transmitted diseases**

**This information has been disclosed to the above named party from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits further disclosure of *highly protected health information* without specific written authorization of the person to whom it pertains. A general authorization for the disclosure of highly protected health information is NOT sufficient for this purpose.**

If applicable and unless directed otherwise by court order, the legal personal representative of a patient, biological parent or legal guardian of a minor (<19 years of age) are the individuals whose responsibility it is to authorize disclosure of the patient's PHI. In the case of a minor consenting to their own services for STD or chemical dependency, the minor and only the minor may authorize disclosure of PHI pertaining to these conditions.

I understand refusal to authorize my PHI disclosure does not effect my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive.

\_\_\_\_\_  
Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Personal Representative Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_ (Documentation attached)  
\_\_\_\_\_  
Notary or Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

This authorization  expires **Six Months** after the date of signature **OR**  **in the event** \_\_\_\_\_ (e.g. of my death, end of research study). However, this authorization may be revoked at any time, through written notice to Family Practice of GI, if received prior to the disclosure of PHI. A photocopy of this authorization shall be considered as valid as the original.

Revocation by \_\_\_\_\_ on \_\_\_\_\_ witnessed by \_\_\_\_\_  
Patient or PR signature Date FP witness signature

**Family Practice Use Only (see reverse side)**

Date Needed \_\_\_\_\_ Date FP received \_\_\_\_\_  
 Date Sent US Mail \_\_\_\_\_ **MD/PA Signature** \_\_\_\_\_  
 Date Picked up \_\_\_\_\_ FP Staff Signature \_\_\_\_\_  
 \$ \_\_\_\_\_ Fee for this request (\$20 handling plus \$0.50/page copied and/or cost-based/x-ray film copied) \_\_\_\_\_  
 No fee for this request  
 Signed completed authorization form was given to patient/personal representative  
 Signed completed authorization form was given to recipient of disclosed PHI

**Designated Record Set**

Business Office

Itemized Statement  
Explanation of Benefits  
Status of Account  
Bank/Loan Information  
Medicare/Insurance Card copies  
Encounter Form

Medical Record

Demographic Information  
Medical Care Information  
National Registry Information  
Diagnostic Information  
PHI Authorizations/Amendment requests  
Insurance Referrals/Information  
Financial Responsibility Information

Not part of the designated PHI record set (not subject to amendment requests)

Insurance Requests  
Subpoenas  
Power of Attorney/Living Wills  
Employment Records  
De-identified Information  
Family Education Rights and Privacy Act (FERPA) Records  
Unincorporated PHI from outside source stating no Redisclosure  
Oral PHI unless it is documented and used to make decisions

**Permitted or Required PHI Use and Disclosure**

1. **No patient *authorization*** is required to use or disclose PHI for:
  - a. TPO-Treatment, Payment or Other Healthcare operations  
Family Practice policy is to obtain *consent* for TPO.
  - b. Department of Health and Human Services (DHHS)
  - c. Public Health
  - d. Federal Drug Administration (FDA)
  - e. Health oversight agencies
  - f. Workers compensation
  - g. Coroners, medical examiners, funeral directors
  - h. Legal proceedings
  - i. Law enforcement
  - j. Criminal activity
  - k. Correctional institution
  - l. Military activity and National Security
  - m. Face-to-face marketing
  - n. Business associates
  - o. Organ, eye and tissue procurement organizations
2. Patient may limit the use or disclosure of PHI in certain special situations.  
See complete NPP.