AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Facility Neutral; Non-Research Related)

The undersigned patient or patient's legal representative requests and authorizes the release of the patient's health records as described below.

A. Patient. The patient whose information may be released is:

Patient's Name (Please Print)	**Patient Date of Birth**	**Patient Social Security No.**

B. Records. I am authorizing release of the following health information (check as applicable):

❑ 1. Portions of the patient's health records (**not including** alcohol and substance abuse testing or treatment, AIDS related information, including HIV status**, if any**) pertaining to: __ the following services received: _____ __ services received by the patient during these dates of Treatment: from _____ to _____
❑ 2. The patient's entire health record, (**not including** alcohol and substance abuse testing or treatment, AIDS related information, including HIV status, **if any**).
❑ 3. The patient's entire health record, **including** alcohol and substance abuse testing/treatment*****, and/or AIDS-related information including HIV status, **if any**). ***Notice to Recipient of Records:** If alcohol and/or substance abuse records are being released to you, such information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of health or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
❑ 4. Additional instructions: **TO PATHOLOGY/HISTOLOGY DEPT**.: Please release the patient's pathology specimens (paraffin blocks) representative of the diagnosis. **Alternatively**, 10 unstained sections on (+) slides per representative block may be provided. (**NOTE**: **This material is NOT for investigational or research use**. It will be used only to guide therapeutic recommendations.)
5. In addition, I □authorize / □ do not authorize the release of my health records, **if any**, pertaining to mental health testing, counseling and treatment.

C. Releasing Provider. The hospital, physician or clinic I am authorizing to release these records is/are:

Name of Releasing Provider (Please Print)	**Releasing Provider's Phone Number:** **Address of Releasing Provider:**
Name of Releasing Provider (Please Print)	**Releasing Provider's Phone Number:** **Address of Releasing Provider:**

D. Recipient. I am authorizing the Releasing Provider to release the patient's health information to:

Name of Recipient of Released Information (Please Print) BRIAN LOGGIE M.D. c/o HOLLY SENNETT, APRN	**Recipient's Phone Number:** (402) 280-5011 FAX (402) 280-3448 **Address of Recipient:** Creighton University Medical Center, Cancer Center 601 North 30th Street, Suite 2803 Omaha, NE 68131

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Name of Recipient of Released Information (Please Print)	**Recipient's Phone Number:** **Address of Recipient:**

E. Purpose of Release. The reason I am authorizing release is:

❑ My request
❑ To provide my health information to another provider
❑ Other (please state)

F. Expiration. This authorization expires 6 months from the date signed unless otherwise indicated below (select one):

❑ Thirty (30) days from the date signed	❑ Other (please state)

G. Explanation of Rights. I, as the patient/patient representative, understand that:

- I have the right to revoke this authorization at any time, provided that I submit my written revocation **to the Releasing Provider.** If the Releasing Party or the Recipient is Creighton University Medical Center, I may also revoke this Authorization by written notice to the Creighton University Privacy Officer Creighton University, 2500 California Plaza, Omaha, NE 68178.
- Any revocation of this authorization does not apply to disclosures already made by the Releasing Provider to Recipient in reliance on this authorization or for disclosures otherwise required by law.
- Neither Releasing Provider nor Recipient may condition treatment, payment, enrollment in its employee health plan or eligibility for employee benefits on whether I sign this authorization
- Health information obtained from other health care professionals, which is in my health record, may be released pursuant to this request unless I specifically advise Releasing Provider not to release such information.
- I have the right to review my health record before signing this authorization. The Releasing Provider's Notice of Privacy Practice explains how to request access to my health record.
- Federal privacy laws protect the information I am authorizing the Releasing Provider to disclose to the Recipient. If the Recipient is not a health care provider, it is possible that the Recipient has no duty to protect the confidentiality of records disclosed to them. There is a risk that the Recipient may re-disclose the information.
- A separate authorization is required for the release of psychotherapy notes.

H. Authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I WILL BE OFFERED A COPY OF THIS AUTHORIZATION FORM UPON SIGNING.

Patient's or Representative's Signature	**Date Signed**
Patient Representative's Name (if applicable; Please Print)	**Patient Representative's Authority (e.g., parent, legal guardian)**