

**Holy Family
Medical Associates**7121 Stephanie Lane
Suite 105
Lincoln, NE 68516
PH 402.484.8383
FX 402.484.7043**Patient Authorization for Disclosure of Protected Health Information
From an external covered entity**I, _____, hereby authorize _____
Patient's Legal Name *Physician, Practice, or Clinic*

to disclose my individually identifiable health information as described below to:

Holy Family Medical Associates, 7121 Stephanie Lane, Suite 105, Lincoln, NE, 68506

For verification purposes, please supply the following information:

Patient's date of birth: _____ Patient's Social Security Number: _____

The following information may be disclosed:

- All medical records generated from the following treatment date(s): _____
- If only specific medical records, please list: _____
- Entire medical record, because it is the necessary minimum required
- Billing records, please list: _____
- Special Limitations: Does this authorization exclude (check all that apply):**
 - HIV/AIDS test results (if part of the medical record)
 - Sexually transmitted diseases
 - Other exclusions (must be specific) _____

Reason for disclosure of the information: _____

This authorization will expire: _____
Expiration date or event (if no date provided, authorization will expire in 180 days)

Prohibition on Conditioning of Authorization: I understand my physician will not condition treatment on my signing this authorization, unless I am receiving research-related treatment or the only reason the clinic is providing me with health care is to make a report to a third party, such as my employer (e.g., fitness to return to work) or school (e.g., P.E. physical).

Redisclosure: I understand that the information disclosed according to this authorization may be redisclosed by the recipient of the information and may no longer be protected by federal law.

Revocation: I understand that I may revoke this authorization at any time by notifying my physician in writing by sending a letter or a completed Revocation of Authorization form to the manager of the clinic at which I receive health care. I understand that if I revoke this authorization, it will not affect any actions that my physician took before my revocation letter was received. For example, my physician cannot rescind disclosures that have already been made, and may use my health information as necessary to bill and collect for services rendered.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in my physician's Notice of Privacy Practices. A fax or photo copy of this authorization shall be considered as valid as the original.

*Signature of patient or personal representative*_____
*Date*Printed name & relationship of personal representative, if applicable:
