SARPY COUNTY
HIPAA RELEASE FORM

Name: _____   Primary Phone: _____

Name/Previous Names: _____

Date of Birth: _____   Social Security Number: _____

Address: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

FROM: _____   **TO:** Sarpy County Human Resources
Health   _____   1261 Golden Gate Drive, Suite 4E
Care   _____   Papillion NE 68046
Provider   _____   Direct Line: 402-593-4486
Info.   _____   Fax: 402-593-5781

Information authorized be disclosed

- ☐ ENTIRE CHART/RECORD
- ☐ Treatment/office exam notes/progress records/consultation reports/other correspondence
- ☐ Laboratory/test reports/results
- ☐ Radiology reports/diagnostic test results
- ☐ Radiology films
- ☐ Prescription orders
- ☐ Hospital records
- ☐ Alcohol and/or drug abuse records
- ☐ Itemized billing statements
- ☐ Other (specify): _____

For the following date(s): _____

Purpose for disclosure: _____

AUTHORIZATION

I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure. I understand that I do not have to sign this authorization and may, in fact, refuse to do so. I understand I may revoke this Authorization at any time by notifying the above-named medical provider in writing of my desire to revoke it. I understand the revocation will not apply to information that has already been released in response to this Authorization. I understand that the medical provider to whom this Authorization is furnished may not condition its treatment of me on whether or not I sign the Authorization. I understand that I may inspect or copy the protected health information sought to be used or disclosed in this Authorization, as permitted by federal law. Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this Authorization will expire in six months.

_____   _____
Patient/Legal Guardian Signature   Date

_____   _____
Print Name, if signed by Legal Guardian   Relationship to Patient, if Legal Guardian

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS AN ORIGINAL