Authorization for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Brown County Hospital 945 E Zero Street Ainsworth, NE 69210 402-387-2804

(Name of person/organization disclosing PHI) Address/Fax

Is authorized to disclose Protected Health Information on the above name patient to:

Johnstown Rodeo Bible Camp Personnel_____

(Name of person/organization receiving PHI) Address/Fax

I specifically authorize the use and/or disclosure of any/all of the following health information and/or medical records, if such information and/or records exist for the following dates:_____

Complete Medical Record Final Summary Dictated & signed Progress Notes

H&P Radiology/Lab Results

The information will be used/disclosed for the following purposes:

To inform Camp Staff that we may knowledgeably inform parents and friends

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

In understand that Brown County Hospital/Ainsworth Family Clinic may receive compensation in exchange for using/disclosing my health information to a third party. (Note: this is not required if the disclosure is requested by the patient)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at tany time except to the extent that action has been taken in reliance of this authorization. This authorization expires_____. **(Insert applicable date or event, may not exceed 180 days)**

_____ _____

Print Name of Personal Representative (if applicable) Relationship to Patient

_____ _____

Signature of Patient or Representative Date