F1.9

| Practice: York Medical Clinic, P.C. |
|---|
| Address: 2114 N Lincoln Ave, Ste. A, York, NE 68467 |
| Privacy Official: Administrator |
| Telephone: 402-362-5555 |

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form authorizes York Medical Clinic, P.C. (YMC) to release your Protected Health Information. Please complete this form if you want YMC to give your Protected Health Information to another person, such as your spouse or employer. "Protected Health Information" (PHI) is information about you that may identify you and relates to your past, present or future physical or mental health or condition and related health services. Please refer to our Notice of Privacy Practices for examples of when **YMC** does not need your authorization to release your PHI. Please print clearly.

## SECTION A: Individual authorizing release of PHI

**YOUR NAME**_____ **DOB#** _____

YOUR TELEPHONE NUMBER: (Day) _____ (Cell) _____

YOUR ADDRESS: _____
Street Apartment #

_____
City State Zip Code

## SECTION B: Description of authorization

I hereby authorize York Medical Clinic, P.C. (YMC) to release my Protected Health Information (PHI) as described in this authorization. I understand that my PHI may include, but is not limited to, the following: medical records, billing statements, Explanation of Benefits, laboratory reports, pathology reports, radiology/ultrasound records and any personal or medical information related to the purpose of this authorization.

I further understand that my PHI may include information related to any of the following: genetic testing, mental health (excluding psychotherapy notes), HIV/AIDS, prescription medication, pregnancy/maternity, organ transplants, and chemical dependency (including alcohol and drug treatment).

This authorization applies to ALL PHI, unless you specify conditions or limitations here:

_____

## SECTION C: Persons authorized to received my PHI

Please tell us who you are authorizing to receive your PHI by completing the table on the next page. Use the table to authorize family members or other individuals to receive your PHI (Example: spouse, friend, and attorney).

- The "Start Date" is the date this authorization will begin.
- The "End Date" is the date this authorization will end. If you do not want this authorization to end on a specific date, leave the "End Date" box blank. This authorization will remain valid until you notify us of an "End Date".

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**TABLE 1: Family Members or Other Individuals Authorized to Receive Your PHI**

| Name of Person to Receive PHI | Person's Relationship to You | Address (City, State, ZIP Code) | Telephone Number | Start Date | End Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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| | | | | | |

Authorized Information will be used and/or disclosed for the following purposes:

- ❑ At the request of the individual (check box if applicable)
- ❑ Other (Please list each purpose of the use(s) or disclosure(s) in the space provided.):

_____

_____

**SECTION D: Terms and conditions of this authorization**

I understand that once released to the person(s) authorized above, my PHI is no longer protected by the federal privacy regulations. I further understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization, unless revoked earlier, this authorization will end on the date specified above.

**SECTION E: Your Signature**

**Signature of Individual:** _____

Date_____

If this authorization is signed by a personal representative on behalf of the individual, please complete the following:

Personal Representative's Name: _____

Relationship to the member (check one of the following):

- ❑ Parent
- ❑ Legal Guardian
- ❑ Power of Attorney