

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

This will authorize:

To release to:

Specific Description of Information to be Released:

<input type="checkbox"/>	Allergy Findings	<input type="checkbox"/>	Immunization Records	<input type="checkbox"/>	Pediatric Findings
<input type="checkbox"/>	Ear, Nose and Throat Findings	<input type="checkbox"/>	Consultation Reports	<input type="checkbox"/>	Lab Reports
<input type="checkbox"/>	X-Ray Reports	<input type="checkbox"/>	Operative Reports		
<input type="checkbox"/>	Other:				

Purpose for which information is to be used:

<input type="checkbox"/>	Treatment/Referral	<input type="checkbox"/>	Insurance	<input type="checkbox"/>	Evaluation
<input type="checkbox"/>	Changing Doctors	<input type="checkbox"/>	Personal/At Request of Patient	<input type="checkbox"/>	Other (Please specify)

Please check any of the following condition(s) that this authorization applies to:

<input type="checkbox"/>	Chemical Dependency/Alcoholism or Abuse	<input type="checkbox"/>	HIV Information	<input type="checkbox"/>	Mental Health Information
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I understand that I may revoke this authorization at any time by sending written notification to Boys Town National Research Hospital Medical Records Department Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire in six months from the date this authorization is signed or _____
(Specify date or event)

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If the patient is unable to give authorization, or physically sign, state reason.

Patient or person authorized to sign for patient

Relationship to Patient

Witness

Date

Patient Name
Medical Record #

BOYS TOWN NATIONAL RESEARCH HOSPITAL
AUTHORIZATION FOR THE RELEASE OF PROTECTED
HEALTH INFORMATION