WEST CENTRAL DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

111 N. Dewey St.
North Platte, NE 69101
308-696-1201

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient's Full Name: _____ DOB: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit#

_____
City State ZIP Code

Phone: _____

I authorize the professional office of West Central District Health Department to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
   - ☐ Complete Records ☐ History & Physical ☐ Lab/Pathology Reports ☐ Immunization Record
   - ☐ Medical Records ☐ Dental Records ☐ X-ray Reports
   - ☐ Records related to specific date(s) of treatment _____
   - ☐ Other (Please Specify)_____

2. Release Information to: _____
   (Name of Individual or Organization)
   Phone # _____ Fax #_____
   Email _____

3. Reason for Release: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

This authorization is effective for 90 days after the date it was signed. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature: _____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name:_____

Signature: _____Date:_____

Location: WCDHD-G/Health Services/Forms/Release of records form
Original: 1/24/2013
Revised: 9/21/2015, 6/18/2018; 8/13/2018