

# OAKVIEW INTERNAL MEDICINE P.C.

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PHONE: \_\_\_\_\_

I hereby authorize the use and disclosure of individually identifiable health information relating to me, otherwise known as "protected health information" or "PHI" under the federal privacy law, as described below. I understand this authorization is voluntary, I consider a copy of this authorization to be valid as the original. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

### PERSON OR ORGANIZATION PROVIDING THE INFORMATION:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### PERSON OR ORGANIZATION RECEIVING THE INFORMATION:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

I specifically authorize the release of data and information relating to me and hereby release Oakview Internal Medicine, P.C. for all legal liability that may arise from the release of sensitive information protected by Title 42 of the Code of Federal Regulations

I understand that I may revoke the authorization at any time, except to the extent that action has already been taken. To comply, by writing to:

Oakview Internal Medicine, P.C.  
Attn: Privacy Official  
2727 South 144<sup>th</sup> Street #100  
Omaha, NE 68144

Without my permission to revoke this authorization, it will automatically expire six(6) months from the date of signature according to Nebraska law.

I understand that I am entitled to a copy of this authorization form I understand that I have the right to inspect or receive copies of my Protected Health Information(PHI) to by used and/or disclosed under this authorization, and that a fee for copies may be imposed by Oakview Internal Medicine, P.C..

Recipient please note this information may have been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations(42/C/F/R/ Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name