City of Lincoln/Lancaster County, Nebraska
Patient Authorization to Use and/or Disclose Protected Health Information

Patient Name: _____Phone: _____

Address: _____
(Address, City, State, Zip Code)

Email: _____ Date of Birth: _____

1) **By signing this Patient Authorization, I consent to the use and/or disclosure by the:**

❒Lincoln Fire & Rescue Department; ❒Lincoln-Lancaster County Health Department;

❒Aging Partners Department; and/or ❒Information Services Department

of the following Protected Health Information (PHI) pertaining to the above Patient for:

❒Immunization Records; ❒Laboratory Results; ❒Dental Records;

❒Billing Information; ❒W.I.C. Records; ❒STI Results; ❒Patient Care Report(s);

❒Complete Medical Record; or ❒_____
(Specific description of PHI to be disclosed)

from _____, 20___ to _____, 20___ .
(Date of Service(s))

2) **This PHI may be disclosed to:**

❒Patient or: ❒_____ .
(name and address or other identification of the recipient the PHI may be disclosed to)

3) **This PHI may be disclosed via:**

❒Encrypted Email to the address listed above; ❒Faxed to: _____ ;

❒Unencrypted Email to* _____ ;
(*Patient/Representative must be warned of security risks to the PHI associated with unsecure transmission before release)

❒ Paper Copy Mailed to address listed above or: _____

❒ In person via: ❒Paper Copy*; ❒CD*; ❒Thumb drive.* (*may have cost of supplies associated)

4) **The purpose for the use and/or disclosure of PHI is:**

❒Patient Request; ❒Litigation; ❒Law Enforcement Investigation;

❒Continuing Education/Quality Improvement; ❒Community Health Promotion;

❒Media Release; ❒Other(specify)_____ .

Revised Jan 2024

5) **Expiration of Authorization - This Authorization expires*:**

❒Upon delivery of PHI; ❒ (Date) _____; or ❒Event_____ .

***Notwithstanding above, any authorization for disclosure shall expire one year from date of signature**

Redisclosure of Information - I understand once PHI is disclosed pursuant to this Authorization the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting my PHI may not apply to third party recipient(s) of the PHI and, therefore, may not prohibit the recipient(s) from further disclosing my PHI, and my PHI could no longer be subject to the privacy protections provided by law.

Right to Refuse to Sign this Authorization - I understand generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my PHI may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign, or not sign, this Authorization.

Right to Inspect - I understand I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization form.

Right to Revoke - I understand that I may revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

-I understand my written authorization is not required for any City of Lincoln Department to use or disclose my PHI for treatment, payment, and healthcare operations.

-I acknowledge I have read the provisions in this Authorization, and I understand and agree to its terms.

Patient Signature: _____ Date: _____

Personal Representative Information (if different from patient):

Name: _____ Relationship to Patient: _____
(Parent, Legal Guardian, Power of Attorney, etc.)

Representative Signature: _____ Date: _____

Address: _____
(Address, City, State, Zip Code)

Translator (If applicable): _____
(Signature) (Printed Name)

- For Administrative Use Only -

❒HIPAA Disclosure Log updated: Date: _____ By Whom: _____