BRITTANY MEYER, MD AND ABBIE FULK, APRN
416 Valley View Dr. Suite 306
Scottsbluff, Nebraska 69361

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "PROTECTIVE HEALTH INFORMATION" (PHI) under a federal health privacy law. I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke this authorization in writing.

I understand and have reviewed the PATIENT PRIVACY NOTICE that provides a more complete description of information, uses and disclosure prior to signing this consent. I understand that Brittany Meyer, MD and Abbie Fulk, APRN reserve the right to change this notice and practice. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and Brittany Meyer, MD and Abbie Fulk, APRN are not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent that Brittany Meyer, MD and Abbie Fulk, APRN have already taken action in reliance thereon.

BY NEBRASKA LAW, we are required to notify you…. that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be released to the following individuals/organizations for the indicated purpose (You may list to whom in the family we may talk to):

_____
_____

I request the following restrictions to the use and/or disclosure of my health information:

_____
_____

Please circle the following questions (Yes or No):

Would you like us to contact you regarding your appointments? Yes No

Do you have an answering machine? Yes No

Can we leave appointment reminders on your answering machine? Yes No

Can we leave medical information on your answering machine? Yes No

PLEASE SIGN AND DATE THIS AUTHORIZATION:

_____ _____

Signature of Patient or Legal Representative ***Date Notice Effective***

FOR THE PHYSICIAN TO SIGN:

Brittany Meyer, MD and Abbie Fulk, APRN accepts _____ denies _____ conditionally the restrictions imposed on release of information as stated above.

_____ _____

Signature/Title ***Date***

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.