CITY OF OMAHA, NEBRASKA

Benefits Division, Human Resources Department
1819 Farnam Street, Suite 506
Omaha, NE 68183

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION.

I hereby authorize _____

Name

_____

Address

_____

City State Zip

to disclose to **Anne Undajon, Privacy Officer (Benefits Director)**

Name of Recipient

City of Omaha, Human Resources Dept,
1819 Farnam Street #506

Address

Omaha **NE** **68183**

City State Zip

records and information pertaining to

_____ _____

Name of Member/Patient (list other names used) Date of Birth

_____ _____

Address Telephone Number

DURATION: This Authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____.

REVOCATION: This Authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial to specify which type of information is to be disclosed.

☐ **MEDICAL INFORMATION** _____ INITIAL

☐ **PSYCHIATRIC INFORMATION**

_____ SIGNATURE _____ DATE

☐ **DRUG/ALCOHOL INFORMATION**

_____ SIGNATURE _____ DATE

☐ **RESULTS OF AN HIV BLOOD TEST**

_____ SIGNATURE _____ DATE

☐ **OTHER HEALTH INFORMATION** _____ INITIAL (specify below)

Specify the records to be disclosed: _____

_____

_____

_____

The recipient may use the health information authorized on this form for the following purposes: _____

_____

_____

_____

Date: _____ Signature: _____

If signed by other than member/patient, indicate relationship: _____