Plains Radiology Services
PO Box 2467
Kearney, NE 68848-2467
(308)234-5520
Fax (308)236-6590

Authorization to Disclose Health Information

1) I hereby authorize Plains Radiology Services to disclose the following information from the health records of:

   Patient Name:_____ Date of Birth:_____

   Address:_____

   Phone #:_____

   Covering the period(s) of health care
   From (date)_____ to (date)_____
   From (date)_____ to (date)_____

2) Please specify the information to be disclosed:
   _____
   _____
   _____
   _____

   I understand that this may include protected health information relating to AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus) infection, and/or psychiatric care, and/or treatment for alcohol and /or drug abuse.

3) This information is to be disclosed to _____ for the purpose of _____.

4) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, even, or condition
   _____.

5) The facility, its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient	Date	Signature of Witness	Date
Or Signature of Legal Rep.	Date	Relationship to Patient	Date
Phone #	Address	City, State	Zip Code