



BEATRICE
CITY • BOARD OF PUBLIC WORKS

CITY HALL

400 Ella Street | Beatrice, NE 68310
Phone: 402.228.5200 Fax: 402.228.2312

SERVICE CENTER

500 North Commerce Street | Beatrice, NE 68310
Phone: 402.228.5211 Fax: 402.223.5181

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

City of Beatrice/Beatrice Fire & Rescue

To use or disclose the following health information: (check one)

- All of my health information

- My health information relating to the following treatment or condition:

- My health information covering the period from _____ (date) to _____ (date)

- Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____



**STAKE
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Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is: (choose all that apply)

At my request _____

Other: _____

This authorization ends: (choose one)

On (date) _____

When the following event occurs: _____

II. My Rights I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____

Date: _____



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If the patient is a minor or unable to sign, please complete the following:

- Patient is a minor: _____ years of age

- Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

- Parent - Legal Guardian - Court Order - Other: _____



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HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF FINANCIAL INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize the following using or disclosing party:

City of Beatrice/Beatrice Fire & Rescue

To use or disclose the following financial information: (check one)

- All of my financial information

- My financial information relating to the following treatment or condition:

- My financial information covering the period from _____ (date) to _____ (date)

- Other: _____

The above party may disclose this financial information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____



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The above party may disclose this financial information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

The purpose of this authorization is: (choose all that apply)

At my request _____

Other: _____

This authorization ends: (choose one)

On (date) _____

When the following event occurs: _____

II. My Rights I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

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Signature of Patient: _____

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