**EXHIBIT A**
**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

| PATIENT'S NAME | BIRTH DATE | ADDRESS |
|---|---|---|
| | | |

**CHECK ONE:**

□ I hereby authorize Nemaha County Community Health Services (NCCHS) to use PHI concerning the above-named person.

□ I hereby authorize NCCHS to disclose PHI concerning the above-named person to _____.

□ I hereby authorize _____ to disclose PHI concerning the above-named person to NCCHS.

**COMPLETE THE FOLLOWING:**

For treatment date(s): _____

For the following purpose(s): _____

***If request is initiated by the individual completing the form, insert "at the request of individual"; otherwise, describe purpose of the use or disclosure.***

**CHECK TYPE OF INFORMATION AUTHORIZED TO BE USED AND/OR DISCLOSED:**

□ Demographic Information
□ Progress Notes
□ Test Results
Other _____
_____
_____
_____
□ Billing Records
□ Entire Record (will not include Billing Records or records not prepared by or on behalf of NCCHS unless those items also are selected).
□ Records not prepared by or on behalf of NCCHS. NCCHS cannot be responsible for the completeness or accuracy of such records.

This authorization shall remain in effect until _____ (date) or _____ (occurrence of specified event) at which time this authorization to disclose the identified health information expires, but no later than one year from the date listed below. If this item is left blank, the authorization shall remain effective for 60 days after the date listed below.

I understand that the records to be used or disclosed pursuant to this authorization may contain records relating to participation in any federally assisted drug and alcohol abuse program. I understand that such information is subject to special protections under federal law. By my initials, I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization. _____ *(initial here)*

I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $_____ per request, a copying charge of up to $0._____ for the first _____ pages and $0._____ for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. If this authorization is for the sale of my protected health information, I understand that this authorization will result in remuneration to NCCHS. I understand that I may revoke this authorization at any time (except to the extent that action has been taken in reliance upon it) by mailing or hand-delivering written notification to the following person: Jane Sunderland RN, Administrator, 1004 Main Street, Sabetha, KS 66534.

_____ _____

*Date* *Patient's Signature*

*If the person giving this authorization is acting as the patient's personal representative, complete the information below:*

| | |
|---|---|
| *Date* | *Personal Representative's Signature* |
| *Printed Name of Representative* | *Representative's Address and Telephone Number* |

**Relationship to Patient [check applicable box]**

- ☐ I am the parent or legal guardian of the minor patient who lacks legal authority to consent to his/her own medical treatment.
- ☐ I have been given authority by a court of proper jurisdiction to act on the patient's behalf, including execution of this authorization.
- ☐ I have been formally appointed by the patient as his or her durable power of attorney and/or durable power of attorney for health care and the patient has an impairment that prevents him/her from making decisions on his/her own behalf.