



Elkhorn Valley Family Medicine

HIPPA - Health Insurance Portability & Accountably Act Effective April 14th, 2003

Effective April 14, 2003 we will not be able to speak to you regarding a patient other than yourself, that is not your biological child that is 18 or under, or is someone whom you have legal guardianship over (legal proof will need to be provided as guardianship).

If someone would like you to be able to obtain information about them or their child you will need to have that individual (over the age of 18) or both the biological parents or legal guardian/guardians sign the consent form below and have it notarized.

CONSENT

I give my informed consent to:

Elkhorn Valley Family Medicine
304 East Douglas Street
O'Neill, NE 68763
Ph: 402-336-4222 Fax: 402-336-4228

to release information about myself/ my child named as _____

to _____. This consent shall be effective until I revoke it. I

understand that I/we may revoke this consent in writing at any time except to the extent that medical information has already been provided at this time.

1) _____

2) _____

(Signature of both biological parents/guardian(s) or self (if 19 or older))

State of Nebraska

County of _____

The foregoing instrument was acknowledged before me this

_____ by _____
(Date) (Name of Person Acknowledged)
