Attachment "B"

Creighton UNIVERSITY
School of Medicine

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFOMATION

Patient's Name: _____ **Date of Birth:** _____

Home Address: _____ **Home Telephone:** __(___)_____

PURPOSE: I authorize **Creighton University Medical Center** to use or disclose my health information during the term of this Authorization for the purpose of allowing students, residents, nurses, physicians and others who are interested in healthcare, pursuing careers in the medical field or desire an opportunity for an educational experience to tour, shadow employees and/or physician faculty members or engage in an Observership.

I understand that once **Creighton University Medical Center** discloses my health information to the recipient, **Creighton University Medical Center** cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **Creighton University Medical Center**.

I understand that **this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to** Creighton University Medical Center's **Privacy Office at the address listed below. The revocation will be effective immediately upon** Creighton University Medical Center's **receipt of my written notice, except that the revocation will not have any effect on any action taken by** Creighton University Medical Center **in reliance on this Authorization before it received my written notice of revocation.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize **Creighton University Medical Center** to use or disclose my health information in the manner described above.

Signature Patient:_____ Date:_____

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures: Signature of Authorized Relationship Date Personal Representative to Patient