

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

## Patient Information:

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

## Information to be released:

I hereby authorize and request records to be released:

\_\_\_\_\_ To or \_\_\_\_\_ From

\_\_\_\_\_ To or \_\_\_\_\_ From

Essential Family Medicine of Omaha  
17520 Wright Street, Suite 105  
Omaha, NE 68130  
Phone: 402-991-5353  
Fax: 1-877-558-1691

\_\_\_\_\_  
Provider Name or Facility

Date of Information to be disclosed: From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ or PRESENT

Information to be released: (Please Check One)

\_\_\_\_\_ The most recent 2 years of pertinent information. (Chart notes, labs, x-rays, and special tests)

\_\_\_\_\_ All medical records

\_\_\_\_\_ Specific Information (please specify): \_\_\_\_\_

Purpose for which information is being used: (Please Check One)

\_\_\_\_\_ Attorney \_\_\_\_\_ Insurance \_\_\_\_\_ Changing Doctors \_\_\_\_\_ Personal \_\_\_\_\_ Referral

## Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Please initial the following to have the information excluded from the records:

\_\_\_\_\_ Drug/Alcohol abuse/treatment diagnosis \_\_\_\_\_ Sexually Transmitted Disease

\_\_\_\_\_ HIV/AIDS Diagnosis/treatment/testing \_\_\_\_\_ Psychiatric, mental health and mental counseling records

## My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients at this facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. This authorization will EXPIRE 90 days from date signed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient, Guardian, or Authorized Representative\*)

\*(Please provide documents to prove authority to sign on behalf of patient)

Possible copying fee required.\*