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**

Essential Family Medicine of Omaha
17520 Wright Street, Suite 105
Omaha, NE 68130
Fax: 402-991-5444

_____**To** or ____ **From**

_____
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.*