AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Home Address: _____

Release of Information From:	**Authorized Information Released To:**
Lincoln Pediatric Group 5625 S. 62nd Street, Suite 100 Lincoln, NE 68516 Phone: 402-489-3834 Fax: 402-489-5049	Clinic: _____ Dr.: _____ Address: _____ Phone: _____ Fax: _____

Information to be released:

☐ Entire Medical Record ☐ Consultations ☐ Lab Results ☐ Operative Reports ☐ Treatment plans ☐ Mental Health

☐ Other: _____ ☐ Date Range Only: ___/___/___ through __/___/____

Information to Omit:

☐ Mental Health Records ☐ Sexual Health Records ☐ Substance abuse (Alcohol/Drugs) records ☐ Other: _____

Purpose of Release:

☐ Continuation of Care ☐ Switching Offices ☐ Moving ☐ Personal Use ☐ Insurance ☐ Other_____

Reason for Transfer: ☐ Appointment availability ☐ Health care ☐ Insurance ☐ Nurse ☐ Other staff ☐ Physician

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the patient(s) listed above to the party identified in the "Release Information To" section.

I understand that:

- Once this information is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.
- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits.
- Certain records (including mental health, substance use, and sexual health) may be protected under additional laws and may require specific authorization.
- Nebraska law allows up to 30 days to process this request.

Expiration & Revocation

This authorization will expire 6 months from the date of signature or when the patient reaches **19 years of age**, whichever comes first. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken based on this authorization.

Important: Patients 19 years or older must sign their own authorization. A separate form may be required if patients have different release instructions

Printed Name: _____ Date: ____/___/_____ Phone # if questions: _____

Signature: _____ Relationship to Patient: _____