



### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_

|                                                                                                                                                                               |                                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <b>Release of Information From:</b><br>Lincoln Pediatric Group<br>5625 S. 62 <sup>nd</sup> Street, Suite 100<br>Lincoln, NE 68516<br>Phone: 402-489-3834<br>Fax: 402-489-5049 | <b>Authorized Information Released To:</b><br>Clinic: _____<br>Dr.: _____<br>Address: _____<br>Phone: _____<br>Fax: _____ |
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#### **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: \_\_\_\_\_