AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I specifically authorize Lincoln Pediatric Group to use and / or disclose protected health information (PHI)

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

Patient's Address: _____

Patient's Phone: _____ Alternate Phone: _____

Release the following Health Information:

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

☐ Entire Medical Record ☐ Inclusive dates only ___/___/___ through __/___/____ ☐ Labs

☐ Other: _____ ☐ Specialist Request

Purpose of Release:

☐ Age of Children ☐ Switching Offices ☐ Moving ☐ Out of State ☐ Out of Lincoln ☐ Personal Use ☐ Insurance

If transferring completely out of LPG please list date you wish to have records transferred, once transferred out of our office we do not consider your child a patient of LPG any longer. Date: _____

Dissatisfied: ☐ Health care ☐ Nurse ☐ Physician ☐ Other staff ☐ Appointment availability

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient(s) to the party identified in the section titled "Release Information To". I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits. **Nebraska State Law allows 30 days from the date of the release to transfer medical records.**

Expiration or Revocation of Authorization: I understand that I may revoke this authorization at any time in writing. This release expires after 6 months of signature or upon patient reaching legal age (19 years of age).

Patient Age: If the patient is 19 years of age or older, the patient MUST sign and date the form.

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

Signature: _____ Relationship to Patient: _____