



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: _____

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

- Entire Medical Record Inclusive dates only ___/___/___ through ___/___/___ Labs
 Other: _____

Purpose of Release:

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

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. 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: _____