Obstetricians & Gynecologists, P.C.
Obstetrics · Gynecology · Infertility

Todd A. Pankratz, M.D.
Jill L. Fish, M.D.
Tyler J. Adam, M.D.

2115 N Kansas Ave, Suite 204 • Hastings, NE 68901 • p 402-463-6793 • f 402-463-6894 • after hours 402-462-8566
3008 W Stolley Park Road, Suite 1 • Grand Island, NE 68801 • p 308-381-1490 • www.obgynnebraska.com

Certified by American Board of Obstetrics & Gynecology / Fellows of American College of Obstetrics & Gynecologists

**Obstetricians & Gynecologists, P.C. Authorization for Use or Disclosure of Health Information**

Patient Name: _____ Date of Birth: _____

Address: _____ City&State_____Zip _____

Home Phone (___)_____ Cell Phone (___)_____

I hereby authorize _____
*(Facility/Provider Name and Location)*

To release health information from the medical record of _____
*(Patient Name)*

To: _____
*(Recipient Name/Address)*

Fax #: _____ Telephone #: _____

For treatment dates: _____
*(Specify dates)*

**Information to be disclosed:**

- ○ Records from last____year(s), including Progress notes, lab and ultrasounds.
- ○ Complete medical record including Progress notes, lab and ultrasounds.
- ○ OB Records date(s) _____
- ○ Lab Reports date(s) _____
- ○ US Reports date(s) _____
- ○ Progress Note date(s)_____
- ○ Other _____

**For the following purpose:**

___ Transfer of Medical Care
___ Insurance
___ Patient request
___ Other (please explain)
___ Legal

Date Needed by: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
**I specifically authorize the release of information relating to:** (check any that apply)

- ○ Substance abuse (including alcohol/drug abuse)
- ○ HIV/AIDS related information (including test results)
- ○ Mental Health

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $20 per request, a copying charge of up to .50 for the first 250 pages and .35 for additional pages, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in PROVIDER'S Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Attn: Office Manager

_____
Signature of Patient or Patient's Personal Representative Date
(Parent/Legal guardian must sign if patient is a minor: NE under age 19

_____
Relationship to Patient, if not the Patient

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original

**OFFICE USE ONLY**

Copied by:_____ Date:_____
_____To be sent/Faxed to #_____
_____To be picked up Date:_____
_____Pick up on Date:_____
Released by:_____
Released to:_____