

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____
Please Print

Address _____ City/State/Zip _____

Phone (_____) _____ UNL ID / Other ID Number _____

I authorize **Provider/Facility Name** _____ Phone (_____) _____

Address _____ City/State/Zip _____

To release my medical information to: **University Health Center** Phone: **402-472-6977**
Attn: Clinic Information Services Fax: **402-472-4593**
1500 U Street
Lincoln, NE 68588-0618

I authorize the **University Health Center** to release my medical information to:

Name (Person/Organization) _____ Phone (_____) _____

Address _____ City/State/Zip _____

Information to be requested/released:

Date(s) of Service:

- | | |
|--|---|
| <input type="checkbox"/> Clinic Progress Notes | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Allergy Records |
| <input type="checkbox"/> Laboratory Test Results | <input type="checkbox"/> Dermatology Records |
| <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Complete Health Record(s) | Other _____ |

From _____

To _____

Purpose

- Medical Care Self
 Insurance Legal/Attorney
Other: _____

Include information relating to:

- Yes HIV testing/infection or AIDS
Yes Psychiatric care/mental health
Yes Treatment for alcohol and/or drug abuse

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 180 days after the date of execution by the patient or their representative.

I may request a copy of this authorization. If I do not sign this form, the University Health Center will not release my information to any person or organization except those authorized by law. My health care or payment for care will not be affected by my refusal to sign. Once disclosed, Federal privacy regulations will no longer apply and the information may be subject to redisclosure. A photocopy of this authorization is as valid as the original.

Patient Signature _____ **Date** _____

Representative/Parent Signature _____

Relationship _____ **Date** _____