University of Nebraska Lincoln

University Health Center

Nebraska Medicine

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(PLEASE PRINT CLEARLY)

Patient Name *(Last, First, M.I.)*		**Date of Birth**
Address	**City** **State**	**Zip Code**
Phone Number	**UNL ID / Other ID Number**	

I authorize *(Provider/Facility Name)*		
Phone Number	**Fax Number**	
Address	**City** **State**	**Zip Code**
To release my medical information to:	**University Health Center** **Attn: Health Information Management** **1500 U Street** **Lincoln, NE 68588-0618**	**Phone: 402-472-6977** **Fax: 402-472-4593**

I authorize the UNIVERSITY HEALTH CENTER to release my medical information to: **Name** *(Person/Organization)*		
Phone Number	**Fax Number**	
Address	**City** **State**	**Zip Code**

Information to be requested/released

- ☐ Allergy Records
- ☐ Clinic Progress Notes
- ☐ Dermatology Records
- ☐ Dietician Notes after 12/1/11
- ☐ History & Physical Exam
- ☐ Immunization Records
- ☐ Laboratory Test Results
- ☐ Physical Therapy
- ☐ X-ray Reports
- ☐ Other _____

Include information relating to

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

Date(s) of Service

From: _____

To: _____

Purpose

- ☐ Medical Care
- ☐ Insurance
- ☐ Legal/Attorney
- ☐ Self
- ☐ Other _____

Method of Disclosure

- ☐ Fax
- ☐ Mail
- ☐ Verbal
- ☐ Will pick up
  Date: _____
  Time: _____

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.
I understand that the individual /institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.
I understand Nebraska Medicine and its affiliates will not condition evaluation or treatment on whether I sign this authorization.
Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Patient Signature _____ Date _____

Representative/Parent Signature _____

Relationship _____ Date _____

University Health Center Record Receipt Acknowledgement

(PLEASE PRINT CLEARLY)

Date: _____

Time: _____

Patient Date of Birth: _____

Print Name of Patient: _____

Signature: _____

Picture ID Verification: _____

UHC Representative Signature: _____