



PT NAME
MR #

Mailing Address: 10304 Crown Point Avenue
Omaha, NE 68134

Fax: (402) 559-6200

1. **Patient Name:** _____ **Birth date:** _____
Address: _____ **Daytime Telephone:** _____
 _____ **SSN#:** _____

2. I hereby authorize and request release of my medical records:

FROM: _____
 (Health care facility to send information)

TO: _____
 (Name of institution or individual to receive information)

 (Street Address)

(City)

(State)

(Zip)

3. Information to be disclosed:

From (date) _____ **to (date)** _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Discharge Summary including Medication Reconciliation | <input type="checkbox"/> EKG/EEG Reports | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Clinic Notes | <input type="checkbox"/> Prenatal (Pregnancy) Records |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Psychiatric Information | <input type="checkbox"/> Physical/Occupational Therapy Notes |
| <input type="checkbox"/> Other (please specify) _____ | <input type="checkbox"/> Laboratory Results | |

4. Purpose of Release: Medical Care Transferring care Attorney Personal records
 Other (please specify) _____

5. 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.

 (Signature of patient)

 (Signature of parent, guardian, or authorized representative)

 (Date)

 (Relationship of above person to patient)

COPY IS AS VALID AS ORIGINAL
AUTHORIZATION FOR RELEASE OF INFORMATION
 White Copy – Medical Record Yellow Copy – Patient