AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____
Date

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

I, _____, hereby authorize **ACCESS FAMILY MEDICINE** to □ receive or □disclose information from the above-named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of _____. I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above-named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the HIPPA privacy rule.

Please send the requested information to:

Access Family Medicine
8101 O Street, Suite 302
Lincoln, NE 68510
Phone: (402) 858-1510
Fax: (402) 858-1511

Specific records being requested:

□ Complete Medical Record
□ Immunizations
□ Specific Records
_____
_____

Provider Releasing the information:

Name:_____

Address:_____

Phone:_____ Fax:_____

_____ _____
Signature of Patient or Legal Guardian Relationship