

515 2ND STREET, FRIEND, NE 68359

3900 S 6th Street, Suite 1, Lincoln, NE 68502

PH: 308-646-2471 FAX: 308-663-3336

**Authorization to Release Health Information**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Complete Rural Medicine to: \_\_\_\_\_\_ Give Health Information TO OR \_\_\_\_\_ Get Health Information From

(Name Person or Place to give the records OR to get the records from) Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address Fax #

Purpose of Disclosure: \_\_\_\_\_\_\_ Transfer of Care \_\_\_\_\_\_\_\_ Personal Record \_\_\_\_\_\_ FMLA \* \_\_\_\_\_\_\_\_ Disability \*\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* If FMLA or Short Term Disability Specify Dates absent from Work and Reason for absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Dates)

(Reasons for Absence)

Information to be Disclosed:

\_\_\_\_\_ H&P \_\_\_\_\_\_ ER Record \_\_\_\_\_\_\_\_\_ Office/Clinic Notes \_\_\_\_\_\_\_\_ Lab Reports \_\_\_\_\_\_\_\_\_\_ Progress Notes \_\_\_\_\_\_ Discharge Report

\_\_\_\_\_ X-Ray Reports \_\_\_\_\_\_\_ Immunization Record \_\_\_\_\_\_\_\_ Complete Record \_\_\_\_\_\_\_\_ Specialty Clinic Record \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I Specifically authorize the release of information relating to:

\_\_\_\_\_ Substance abuse (including drug/alcohol abuse)

\_\_\_\_\_ Mental Health

\_\_\_\_\_ HIV/AIDS related information (including test results)

Date(s) of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (State: specify dates, time period or “ALL”

*I understand that:*

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Complete Rural Medicine.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to he Health Information Director. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) this document and this disclosure is at my request.
5. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature or Legal Representative signature and their relationship to patient Date

Date received:

Date record sent:

☐Fax ☐ Mailed ☐Picked Up

MR#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd Witness required for phone authorization Date

Note: This facility, its employees and officers and attending physicians are released from the legal responsibility or liability for the release of the above information to the extent indicated and authorized.

\* Complete Rural Medicine, LLC may charge standard applicable fees for processing and furnishing information. Patient will be notified. \*\*