NEBRASKA INTERNAL MEDICINE, P.C.

Authorization for Use and Disclosure of Protected Health Information

From: _____ **To:**_____

_____ _____

_____ _____

Phone:_____ **Phone:**_____

Fax:_____ **Fax:**_____

REGARDING:

Patient Name:_____ **DOB:** _____

Patient Address:_____ **Phone:** _____

Please disclose the following information from my records for:
Dates ___/___/___ to ___/___/___

___ History and Physical
___ Physician Progress Notes
___ X-Ray Reports
___ Laboratory Reports
___ Medication List
___ All medical records at this facility for the **last 3 years only.**
Excluding actual x-ray films, unless specified.
___ Other (specify) _____

The information will be used for the purpose of:

___ The patient's use
___ Changing Physicians
___ Consultation/Second opinion
___ Insurance
___ Social Security Disability Appeal (**Note:** Initial Social Security disability requests are sent by the Social Security office.)
___ Legal proceedings (we request the reason for proceeding)
_____
___ Other (specify use) _____

I specifically authorize release of information relating to:

Sexually transmitted disease	Yes ____ No ____ N/A ____ Initial ____
Genetic Testing	Yes ____ No ____ N/A ____ Initial ____
Human Immunodeficiency Virus (HIV)	Yes ____ No ____ N/A ____ Initial ____
Behavioral or Mental Health services	Yes ____ No ____ N/A ____ Initial ____
Treatment for drug or alcohol abuse	Yes ____ No ____ N/A ____ Initial ____

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I have signed it.

I understand that I may revoke this authorization at any time by notifying the Privacy Officer at Nebraska Internal Medicine, P.C., 770 N Cotner, Suite 220, Lincoln, NE 68505, in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.

Unless otherwise revoked, this authorization will expire in one year or as specified, _____.
Date

I understand that authorizing the disclosure of this health information is voluntary. I understand that by authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.

For records furnished to third parties, with the exception of other medical professionals, there will be a charge assessed per Nebraska Statute of $20.00 handling and $0.50 per page. There may also be a fee charged to patients for records for their personal use based on the amount of records produced and labor costs.

_____ _____
Signature of Patient Date

_____ _____
Legal Guardian or Authorized Person Relation to Patient

If information is being picked up by someone other than patient, please state below:

_____
ID will be requested.