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|  | Please note: If any section is incomplete, the form becomes invalid. |
|  | Name: |
| **Patient:** | Address: |
|   | City: State: Zip: |
|   | Date of Birth: Phone:  |
| **Provide**  | I authorize the following facility/provider to release my health information upon my request: |
| **address** | Name: |
| **of previous** | Address: |
| **Physician:** | City: State: Zip: |
| **Health**  | I authorize my health information be disclosed to : |
| **Information** | Hart & Arndt Family Health, PC Phone: (402) 488-5972  |
| **disclosed to:** | 8055 O Street, Suite 200 Fax: (402) 488-5974 |
|  | Lincoln, NE 68510-2565 |
|   | Please note: If dates are not provided, only the past two years will be provided. |
|   | Yes No Copies of clinical notes From (date) To (date) |
| **Health**  | Yes No Copies of hospital records From (date) To (date) |
| **information** | Yes No Lab records From (date) To (date) |
| **to be** | Yes No Radiology reports From (date) To (date) |
| **disclosed:** | Yes No HIV/AIDS testing/treatment From (date) To (date) |
|   | Yes No Alcohol/Drug abuse eval From (date) To (date) |
|   | Yes No ALL of the above / Other From (date) To (date) |
| **Reason** | \_\_\_\_Consult/second opinion \_\_\_\_\_Disability \_\_\_\_\_ Legal |
| **for request** | \_\_\_\_\_Change of doctor \_\_\_\_\_Personal \_\_\_\_\_Other |
|  | I understand that I have the right to revoke my authorization at any time. I understand that if I |
|  | revoke this authorization, that I must do so in writing and present my written revocation to the |
|  | Privacy Officer. I understand that the revocation will not apply to my insurance company when the |
| **Revocation** | law provides my insureer with the right to consent a claim under my policy.  |
|  | **I understand that this authorization will be in effect for 90 days from the date signed unless** |
|  | **revoked by me in writing.** |
|  | I understand that authorizing the release of this information is voluntary, I understand that I may have to access |
|  | to my health information. I understand that any release of information carries with it the potential for an  |
|  | unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I under- |
|  | stand that Hart Family Health is not responsible for electronic or paper records re-disclosure once the records  |
| **Authorization** | have been released to the patient or facility.  |
|  | **Please allow up to 30 days to process the release. Copying fee: $20 + .50 per page may apply.**  |
|  | **(personal and legal reasons).** |
|  | Patient Signature (age 19 and older must sign or legal guardian) Date:  |
|  | Relationship to patient/authority Date: |