AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION / MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____
Last First Middle Initial

□ Sending records to Women's Clinic of Lincoln; please check this box and fill out the information below	□ Sending records to another facility; please check this box and fill out the information below
From: **Name:** **Address:** **Phone:** **Fax:**	**From: Women's Clinic of Lincoln** **220 Lyncrest Drive** **Lincoln, NE 68510 (402) 434-3370**
To: Women's Clinic of Lincoln **220 Lyncrest Drive** **Lincoln, NE 68510** **Phone: (402) 434-3370** **Fax: (402) 489-0731**	**To:** **Name:** **Address:** **Phone:** **Fax:**

Information to be disclosed:

___ Records from the last ____ year(s)
___ Complete medical record (last five years)
___ Progress note(s), date(s)_____
___ Radiology reports (Ultrasounds, DEXA, or Mammograms), date(s)_____
___ OB records, date(s) _____
___ Lab reports, date(s) _____
___ Other_____

For the following purpose:

___ Transfer of Medical Care
___ Insurance or Legal
___ Patient request
___ Continued Medical Care
___ Other (please explain)

Date needed by: _____
Records will be sent in 7 to 10 business days unless otherwise specified.

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of information relating to: (check any that apply)

___ Substance abuse (including alcohol/drug abuse)
___ HIV/AIDS related information (including test results)
___ Mental Health

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to $45 per request, a copying charge of 0.50 per page and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Provider's Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Attn: Office Manager. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.
Please note: If a patient is requesting a copy of their complete medical record for personal use, the $45-copying fee will apply.

_____
Signature of Patient or Patient's Personal Representative Date
(Parent/Legal guardian must sign if patient is a minor: NE under age 19)

_____
Relationship to Patient, if not the Patient

Office Use Only
Date Mailed: _____
Date Faxed: _____