RECORDS TRANSFER REQUEST

Patient Authorization for Use and Disclosure of Protected Health Information

Lincoln Family Medical Group, PC 7441 O Street, Suite 300 Lincoln NE 68510-2497

Phone 402-488-7400 Fax 402-488-0739

_____ ___/___/_____ _____

PATIENT'S FULL LEGAL NAME DATE OF BIRTH PHONE NUMBER

By signing this authorization, I authorize:

Name/Facility:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____ Fax:_____

To disclose certain protected health information about me to:

Name/Facility:_____

Address:_____City:_____State:_____Zip:_____

Phone:_____ Fax:_____

Circle one of the following:

Complete record Medical/Surgical History Hospital Records Laboratory Testing

Office Visit Notes Medication List Immunizations Medical Imaging Reports

Other (please be specific)_____

Dates of service requested: From _____ (date) to _____

YOU MUST CHECK ONE OF THE FOLLOWING TWO OPTIONS:

___ I authorize the release of sensitive information regarding HIV/AIDS, treatment for alcohol/substance abuse, and mental health records

___I DO NOT authorize the release of sensitive information regarding HIV/AIDS, treatment for alcohol/substance abuse, and mental health records

This information may be used/disclosed for each of the following purposes:

___ For my healthcare ___ For legal purposes ___ For payment/insurance purposes

___ For employment purposes ___ Other (please be specific) _____

This authorization shall expire on ___/___/_____ OR ( ) when I revoke it in writing.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or affect my eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that I have the right to revoke this authorization in writing and a written revocation will only apply to further disclosures or actions. My written revocation must be submitted to the person or office who was authorized to disclose my information.

Signed by:_____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print name of Patient or Legal Guardian Date