LINCOLN FAMILY MEDICAL GROUP, P.C.
7441 O Street, Suite 300
Lincoln, NE 68510
T (402) 488-7400
F (402) 488-0739

Authorization to Release Information to Friend, Relative or Caretaker

Patient authorization to allow friends or relatives such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information.

1. **Patient Information:**

First Name: _____ MI: _____ Last Name: _____ Date of Birth: _____

2. **By signing this authorization, I authorize: Lincoln Family Medical Group 7441 O Street, Suite 300 Lincoln, NE 68510 to disclose my complete health record to the following individual:**

First Name: _____ MI: _____ Last Name: _____ Relationship to Patient: _____

3. **I DO NOT authorize the release of the following sensitive information (Please select all that apply):**

☐ Mental Health Records ☐ Treatment for Alcohol/Substance Abuse ☐ HIV/AIDS Diagnosis and/or Testing

I understand that after my health information is disclosed, 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 of 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.

I understand that this authorization will remain in effect unless revoked by me in writing.

4. Printed Name: _____ Relationship to Patient: _____ Date: _____

_____
Signature