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

Record Transfer Request

Patient Authorization for the Release of Protected Health Information

1. Patient Information:

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

2. By signing this authorization, I authorize: Lincoln Family Medical Group 7441 O Street, Suite 300 Lincoln, NE 68510

○ to send my Health Records to: ○ to receive my Health Records from:

Name/Facility: _____ Address: _____ City: _____

State: _____ Phone: _____ Fax: _____

3. Health information to be disclosed:

- ☐ Complete Record
- ☐ Medical/Surgical History
- ☐ Hospital Records
- ☐ Laboratory Testing
- ☐ Office Visit Notes
- ☐ Medication List
- ☐ Immunizations
- ☐ Medical Imaging Reports
- ☐ Other (Provide Details Below)

4. 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

5. Dates of Service Requested:

From: _____ To: _____

6. Reason for Request:

- ☐ Continuity of Care
- ☐ Change of Doctor
- ☐ Legal
- ☐ Payment/Insurance
- ☐ Employment
- ☐ Other (Provide Details Below)

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 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 be in effect for 90 days from the date signed unless revoked by me in writing.

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

_____
Signature