Fallbrook Family Health Center
(402) 441-3575
Fax (402) 438-2107

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Please note: If any section is incomplete, this form becomes invalid.

Patient:	Name:		
	Address:		
	City:	State:	Zip:
	Date of Birth:	Phone:	
Health Information To Be Disclosed From:	**I authorize the following facility/provider to release my health information upon my request:**		
	Name: Fallbrook Family Health Center		Phone: 402-441-3575
	Address: 755 Fallbrook Blvd, Suite 100		Fax: 402-438-2107
	City: Lincoln	State: NE	Zip: 68521
Health Information To Be Disclosed To:	**I authorize my health information be disclosed to:**		
	Name:		Phone:
	Address:		Fax:
	City:	State:	Zip:
Health Information To Be Disclosed:	**Please Note: If dates are not provided, only the past two years will be provided.**		
	☐ Copies of Clinical Notes	From (date):	To (date):
	*Clinical Notes include: Past Medical History, Medical Problems, Inactive Medical Problems, Surgeries, Gynecologic History, Tests, Immunizations, Current/Past Medications, Allergies, Social History, Family History		
	☐ Laboratory Records	From (date):	To (date):
	☐ HIV/AIDS Testing/Treatment	From (date):	To (date):
	☐ Alcohol/Drug Abuse Evaluation	From (date):	To (date):
	☐ ALL of the above / OTHER	From (date):	To (date):
	Are you requesting any exclusions? BE SPECIFIC. _____		
Reason for Request:	☐ Consult/Second opinion ☐ Change of Doctor	☐ Disability ☐ Personal	☐ Legal ☐ Other
Revocation	I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that 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 law provides my insurer 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.**		
Authorization	I understand that authorizing the release of this information is voluntary. 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 understand that Fallbrook Family Health Center is not responsible for electronic or paper records re-disclosure once the records have been released to the patient or facility. I understand that a copy of this form will be sent with my records. **Please allow up to 30 days to process this release.** **Copying fee: $20 + .50 per page may apply. (personal and legal reasons)** **A fee of $35 will be charged if any exceptions above require omissions from the medical record.**		
	Patient Signature (Age 19 and older must sign or legal guardian)		Date:
	Relationship to patient/Authority		Date: