



755 FALLBROOK BLVD
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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:	

I authorize the release of my Protected Health Information between the following entities:

Circle Selection: TO or FROM

Circle Selection: TO or FROM

Fallbrook Family Health Center
 755 Fallbrook Blvd., Suite 100
 Lincoln, NE 68521

Health Information To Be Disclosed	Please Note: If dates are not provided, only the past two years will be provided.		
	<input type="checkbox"/> Copies of Clinical Notes	From (date):	From (date):
	<input type="checkbox"/> Copies of Hospital Records	From (date):	From (date):
	<input type="checkbox"/> Laboratory Records	From (date):	From (date):
	<input type="checkbox"/> Radiology Reports	From (date):	From (date):
	<input type="checkbox"/> HIV/AIDS Testing/Treatment	From (date):	From (date):
	<input type="checkbox"/> Alcohol/Drug Abuse Evaluation	From (date):	From (date):
	<input type="checkbox"/> Other _____		
Reason for Request	<input type="checkbox"/> ALL of the above / OTHER	From (date):	To (date):
	<input type="checkbox"/> Consult/Second opinion	<input type="checkbox"/> Disability	<input type="checkbox"/> Legal <input type="checkbox"/> Personal
	<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Continuity of Care Only	<input type="checkbox"/> 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		
Authorization	I understand that authorizing the release of this information is voluntary, I understand that I may have access to my health information. 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. Please allow up to 30 days to process this release. Copying fee: \$20 + .50 per page may apply. (personal and legal reasons)		
	Patient Signature (Age 19 & older must sign or legal guardian)		Date:
	Relationship to patient/Authority		Date:

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