AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing this authorization, I specifically authorize Lincoln Pediatric Group to use and / or disclose protected health information (PHI)

Patient's Name: _______________________________________ DOB: ___________________

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Patient's Name: _____________________________________ DOB: ___________________

Patient's Name: ____________________________________ DOB: ___________________

Patient's Address: ____
Patient's Phone: ____________________________ Alternate Phone: ______________________

Authorized Information Released From:	**Please Send My Records To:**
Lincoln Pediatric Group	**Clinic:** _______________________________________
4501 S. 70th Street, Suite 110	**Dr :** _______________________________________
Lincoln, NE 68516	**Address:** _____________________________________
Phone: 402-489-3834	**Phone:** ______________________________________
Fax: 402- 489- 5049	**Fax:** _______________________________________

Release the following Health Information:

☐Entire Medical Record ☐Inclusive dates only ___/___/___ through __/___/____ ☐Labs
☐Other: ___________________________

Purpose of Release:

☐Age of Children ☐Switching Offices ☐Moving ☐Out of State ☐Out of Lincoln ☐Personal Use ☐ Insurance

Dissatisfied: ☐Health care ☐Nurse ☐Physician ☐Other staff ☐Appointment availability

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient(s) to the party identified in the section titled "Release information to). I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits. **Nebraska state law allows 30 days from the date of the release is received to transfer medical records.**

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.
Reimbursement: LPG reserves the right to recover cost involved in producing the requested information. You or the recipient of the records may be charged $6 for handling and copying this information.
Patient Age: If the patient is 19 years of age or older, the patient MUST sign and date the form.

Printed Name: ____ Date: ___/___/____ Phone # if questions: __________________

Signature: ____ Relationship to Patient: __________________________________