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: ______________________

Release the following Health Information:

Authorized Information Released From:	**Release Information 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:** ____

☐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 to transfer medical records.**

Expiration or Revocation of Authorization: I understand that I may revoke this authorization at any time. This release expires after 6 months of signature or upon patient reaching legal age (19 years of age).

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: ______________________________

Revised 7/8/21