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: _____

Patient's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____

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:**
Clinic: _____	**Lincoln Pediatric Group**
Dr: _____	**4501 S. 70th Street, Suite 110**
Address: _____	**Lincoln, NE 68516**
Phone: _____	**Phone: 402-489-3834**
Fax: _____	**Fax: 402- 489- 5049**

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 / revocation of authorization: I understand that I may revoke this authorization at any time. This release expires after 6months of signature or upon patient reaching legal age of majority. (Which is 19years of age.)
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: _____