Pediatrics, P.C.
Infancy through Adolescence

7001 A Street, Suite 110, Lincoln, NE 68510
Phone: 402-489-0800
Fax: 402-489-6803

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I specifically authorize Pediatrics, PC to use and/or disclose certain 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:_____

Authorize Information Released From:

Pediatrics PC
7001 A Street
Suite 110
Lincoln, NE 68510

Please Send My Records To:

_____
_____
_____
_____
_____

Purpose of Release: (check all that apply)

☐ Immunization Record
☐ Age
☐ Moving: ☐out of State ☐ out of Lincoln
☐ Switching Offices
☐ Dissatisfied: ☐health care ☐ nurse ☐physician ☐other staff ☐appointment availability

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I understand this authorization may be revoked in writing at any time. Unless otherwise revoked, this authorization expires in 90 days.

Pediatrics, PC and its employees, officers and physicians are hereby released from any and all legal responsibility or liability as to any disclosure of any documents generated by any health care provider other than Pediatrics, PC. Pediatrics, PC does not attest to, warrant nor guarantee the accuracy of completeness of documents from other health care providers.

Nebraska State Law allows 30 days from the date the release is received to transfer medical records
There is a fee of $20 + .50 per page for medical records going directly to the family for personal use.
excludes immunization records

_____ _____ _____
Patient (must be 19)**/Guardian/Legal Representative** **Relationship to Patient** **Date**