**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:**Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Purpose of Release: (check all that apply)**

 □ Immunizations □ Operative Reports □ Consultations □ Ear, Nose, & Throat

 □ Encounters □ Lab Reports □ Mental Health Records □ Treatment Plan □ Audiological

 □ Allergies □ History& Physical □ Physical Form □ X-Ray Reports □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of Release:**

□Age □ Switching Offices □ Moving: □ Out of State □ Out of Lincoln

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

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\***

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