



305 N. 37<sup>th</sup> St. Norfolk, NE 68701-3275  
P: 402-370-4100 F: 402-370-4101

### Authorization of Release of Information

To avoid delays in obtaining records please make sure all information is complete and legible.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Maiden: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, and Zip code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

This authorizes:

To release to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For the purpose of \_\_\_\_\_ on going care \_\_\_\_\_ take to another physician \_\_\_\_\_ personal records \_\_\_\_\_ insurance records  
\_\_\_\_\_ other \_\_\_\_\_

The following information:

\_\_\_\_\_ Final Discharge Summary      \_\_\_\_\_ History and Physical      \_\_\_\_\_ X-Ray reports  
\_\_\_\_\_ Operative Reports              \_\_\_\_\_ Lab Reports                      \_\_\_\_\_ EKG reports  
\_\_\_\_\_ Emergency Room records      \_\_\_\_\_ other \_\_\_\_\_

#### Specific Authorization for release of information protected by state/federal law

- If this authorization applies to any of the following: this authorization will last no longer than reasonably necessary to serve the purpose for which it is given, or as limited in paragraph 2 hereof, which is sooner. Please designate if the records apply to any of the following:  

_____ chemical dependency or abuse	_____ alcoholism or alcohol abuse
_____ infection with Human immunodeficiency virus (HIV)	_____ drug abuse
_____ mental health records	_____ psychotherapy records
- I understand that I may revoke this authorization at any time by submitting a written request to Health Information management department of Sunny Meadow Medical Clinic, PC. However to the extent that action has already been taken, a revocation will not be possible. Without my permission to revoke this authorization and except as otherwise provided herein, it will automatically expire on the sooner of: after 6 months from the date of signature per Nebraska Rev. Statue Sections 71-8401 to 8407, or up on satisfaction of the need for disclosure, unless specific date stated.
- I understand and agree that Sunny Meadow Medical Clinic, PC cannot control the re-disclosure by recipient of the information disclosed to them provided, however, alcohol, chemical drug abuse patient records which are disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.
- I hereby release Sunny Meadow Medical Clinic, PC from all liability that might arise from their release of the information or the re-disclosure of the information of the recipient. I consider a photocopy of this authorization to be valid as the original.

Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If the patient is unable to give authorization, or physically sign, state reason: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or person of authorized consent for patient

\_\_\_\_\_  
Date

Office Use only    Copied by \_\_\_\_\_ Date \_\_\_\_\_ Date mailed or faxed \_\_\_\_\_