AUTHORIZATION FOR USE and/or DISCLOSURE
of
PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient: _____ Date of Birth: _____ SS#: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

I authorize the release of my Protected Health Information between the following entities:

***Circle Selection*: TO or FROM**

Capital Medical Clinic, LLP
4701 Normal Blvd.
Lincoln, NE 68506
Phone (402) 488-5050 Fax (402) 488-5001

***Circle Selection*: TO or FROM**

_____
Name of Doctor/Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*
☐ Complete Medical Record
☐ Other: _____

FOR THE FOLLOWING DATES: From: _____ To: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (please check all that apply)

☐ HIV/AIDS related testing and results ☐ Mental/Behavioral Health Conditions ☐ Chemical Dependency (Drug/Alcohol Abuse)

Signature: _____ Date: _____

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

☐ Continuing Care ☐ Transfer to New Provider ☐ Insurance/Claim Purposes ☐ Legal ☐ Personal Use ☐ Disability Determination

☐ Workers Compensation ☐ Other: _____

You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. Revocation must be made in writing and presented to Capital Medical Clinic, LLP. Revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire one year from the date signed.

_____ _____
SIGNATURE OF PATIENT/LEGAL REP **DATE**

_____ _____
If signed by Personal Representative, Print Name Relationship to Patient

_____ _____ _____
Power of Attorney – Print Name **Signature** **Date**
(Please provide *Capital Medical Clinic, LLP* with a copy of the POA)