Capital Medical Clinic

4701 Normal Blvd Lincoln, Nebraska 68506

Phone 402-488-5050 Fax 402-488-5001

Authorization to Release Private Health Information (PHI)

I hereby authorize Capital Medical Clinic to release my PHI (private health information) to the following people. This authorization will remain in effect until I complete a new Authorization to Release PHI form.

Name _____
relationship

Name _____
relationship

Name _____
relationship

Name _____
relationship

Name _____
relationship

Privacy Protection:

OK to call you at work?	Y	N	N/A
OK to speak to your spouse about medical and billing information?	Y	N	N/A
OK to leave medical and billing information on your home voice mail?	Y	N	N/A
OK to leave medical and billing information on your cell phone voice ma	Y	N	N/A

_____

Patient signature, signature of parent/guardian of minor patient or POA Date

_____

Please print your name (please use your legal name or the name on your insurance card) relationship to patien

(Revised 05/2014)