



BryanLGH Heart Institute

1600 S. 48th Street, Suite 600 • Lincoln, NE 68506 • Phone 402/483-3333 • Fax 402/483-3334

AUTHORIZATION FOR REQUEST OF RELEASE OF MEDICAL INFORMATION

(Please Print)

Patient's Legal Name: _____

Patient's Nickname: _____ **DOB:** ____/____/____ **Age:** ____

Address: _____

City/State/Zip Code: _____ **Phone Number:** _____

Records to Request/Release:

- | | |
|---|--|
| <input type="checkbox"/> Complete Cardiology Record | <input type="checkbox"/> Lab and X-ray Report |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Doppler Report |
| <input type="checkbox"/> History and Physical Examination | <input type="checkbox"/> Cath/PTCA Report |
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> X-ray Films |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Cine Films |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Financial Information |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Billing Information |
| | <input type="checkbox"/> Other (Specify) _____ |

Reason for Release:

- To update my Primary Care Provider
- I have been referred to another physician
- I want/need a second opinion
- I am changing doctors due to:
 - Insurance change
 - Dissatisfaction with care
 - Moving to a new address
- Other: _____

Date(s) of Service needed: ____/____/____ to ____/____/____

This authorization gives my permission and consent to **REQUEST**, from the following described facility, those medical records and test results checked above regarding medical treatment and care that I have received at such facility:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

OR

This authorization gives my permission and consent to **RELEASE** those medical records and test results checked above regarding medical treatment and care that I have received from BryanLGH Heart Institute to the following:

Name: _____

Address: _____

City/State/Zip: _____

Phone/Fax: _____

Mail or Fax to:

**BryanLGH Heart Institute
1600 South 48th Street, Ste 600
Lincoln, NE 68506
FAX: 402-483-3334**

I understand that:

- BryanLGH Heart Institute **may refuse health care services** to me if I fail to sign an authorization if the treatment is for **research purposes**.
- Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
- My signature releases BryanLGH Heart Institute from all legal liability that might arise from the release of this information or the re-disclosure of the information by the recipient.
- A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.
- I may revoke** this authorization at any time, except to the extent that **action has already been taken**, a revocation will not be possible, by following the procedures provided for in a BryanLGH Heart Institute's Notice of Privacy Practices. Without my permission to revoke this authorization and except as otherwise provided herein, it will automatically expire six (6) months from the date of signature, or upon satisfaction of the stated need for disclosure, or as specified:
Date(s) information needs to be disclosed: _____ through _____.
- I have read (or had read to me) this document. This document and disclosure are at my request.

Date

Signature of Patient or Patient's Authorized Representative

Physician Signature of Consent

Date Completed: ____/____/____

GENERAL ROI REV04/22/10