Southeast Lincoln Family Medicine
BRYANLGH PHYSICIAN NETWORK
4424 S. 86th Street • Lincoln, NE 68526
402-483-8500 • Fax 402-483-8501

CONSENT TO RELEASE INFORMATION

Patient Name: ______________________ Other Names Used: ______________

Address: ______________________ Date of Birth: ______________

Phone Number: ______________________

I hereby authorize Health information to be released FROM:

____
(Name of Person/Agency)

____
(Phone, Fax & Address of Person/Agency)

I hereby authorize Health Information to be released TO:

____
(Name of Person/Agency)

____
(Phone, Fax, & Address or Person/Agency)

______________________ ______________
(Signature) (Date)

❑ Individual ❑ Parent (if individual is under 19 years of age) ❑ Legal Guardian

______________________ ______________
(Witness) (Date)

❑ Complete Medical Record ______________________

❑ Other ______________________

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of date and information relating to: (check appropriate box below)

1.	Substance Abuse (alcohol/drug abuse)	❑ Yes	❑ No	❑ Does Not Apply
2.	Mental Health (includes psychological testing)	❑ Yes	❑ No	❑ Does Not Apply
3.	HIV/AIDS Related Information	❑ Yes	❑ No	❑ Does Not Apply

____
(Signature of Patient or Legal Guardian)

THIS AUTHORIZATION FOR RELEASE OF INFORMATION SHALL REMAIN IN EFFECT NO LONGER THAN NINETY (90) DAYS.

PLEASE NOTE: THIS INFORMATION MAY HAVE BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATION (42 C.F.R. PARTW) PROHIBITS YOU FROM MAKING ANY FURTHER DISCLOSURE WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. PLEASE ALLOW UP TO 30 DAYS FOR THIS RELEASE TO BE COMPLETED.

Form 003 (04/08)