Women's Health of Northeast Nebraska

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Norfolk, NE 68701-3120
(402)379-9999
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION

Patient Name: _____ DOB: _____ Previous Name: _____

Address: _____ City: _____ State: _____

I, the above patient, authorize Dr. James Albin, Dr. Renee Albin and/or Kristie Lubischer, APRN to:

( ) release records **TO:**

_____
Name of Healthcare Facility/Physician

_____
Street Address

_____
City/State/Zip Code

(_____)_____
Fax Number (Required)

( ) receive records **FROM:**

_____
Name of Healthcare Facility/Physician

_____
Street Address

_____
City/State/Zip Code

(_____)_____
Fax Number (Required)

Specify information to be released: Dates from: _____ to: _____

I specifically authorize the release of data and information relating to: ***MUST INITIAL *ALL* THAT APPLY. (AIDS/HIV, Mental Health and Drug/Alcohol cannot be released unless specifically initialed).**

_____ Complete Records
_____ History & Physical Examinations
_____ Progress Notes
_____ Xrays, Lab & EKG Reports
_____ Dr. _____'s records only
_____ Hospital Records

_____ ***AIDS/HIV Tests and/or information**
_____ ***Mental Health**
_____ ***Drug/Alcohol**
_____ Pathology Reports
_____ Other/specify: _____

The purpose of this disclosure of information is:

_____ To update my Primary Care Provider
_____ I have been referred to another physician
_____ I desire/need a second opinion

_____ I am changing physicians due to:
_____ Moving/New address
_____ Other: _____

_____

I fully understand that if I refuse to sign this authorization, my medical record information will not be released. This release does **NOT** include hospital records or records from another physician that have been sent to this clinic. However, for insurance purposes, hospital records may be included.
I understand that this consent is revocable at any time prior to the release of this information. This authorization will expire 90 days from the date below.

_____ Date: _____
(Signature of patient or legal guardian if 19 years or younger)

_____ Date: _____
(If signed by other than patient, state relationship)

_____ Date: _____
(Signature of witness)

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APPROVED BY: _____ RECORDS MAILED/FAXED ON: _____ PICKED UP: _____

Explanation of Release of Information:

- At Women's Health, we will release to referring physicians to provide continuity of care for a patient. The patient will sign a "blanket" release of information at the time of intake for referred releases.
- Patients, however, will be asked when possible to sign a specific release of information at the time of their office visit for release of information to a referring physician.
- Women's Health will not release records received from other offices, including physician correspondence from other clinics to another referring physician.
- Women's Health will avoid verbal release of information, with the exception of when there is a phone conversation between medical care providers (physician/nurse/office personnel) regarding a health concern, or a referral to that office is initiated.
- We will no longer be able to honor verbal requests for release of information that are initiated by the patient via telephone.

***Inclusive in the records may be information regarding alcohol and drug usage, or reference to HIV or STD testing and results. This information may be a part of the history and/or secondary to the primary objective of the visit, but necessary for treatment. It cannot be extracted from the office visit documentation when sending records.**