

I authorize _____ to release the following information on _____

Patient's Name / Date of Birth / Last 4 digits of Social Security Number

to _____ (Recipient)
Name/Title
Street Address City State Zip Code
Home Phone # Work Phone # Fax #

1. Date(s) of information to be disclosed: _____ through _____

- 2. Information to be disclosed during designated dates:
[] Discharge Summary [] Emergency Department Report [] Lab and X-ray Report
[] Operative Report [] Progress Notes [] History and Physical Examination
[] X-ray Films [] Consultation Report [] School Assignment and Transcription
[] After Care Plan [] Team Staffing Plan [] Complete Record
[] Chemical Dependency Evaluation Assessment [] Financial Record
[] Other (specify): _____

3. Purpose for which information is to be used:
[] Treatment [] Insurance [] Personal
[] Follow-up [] Legal Proceedings [] Other (specify): _____

4. If this authorization applies to any of the following, this authorization will last no longer than reasonably necessary to serve the purpose for which it is given, or, as limited in paragraph 5 hereof, whichever is sooner. Please designate if the records apply to any of the following:
___ Alcohol or Drug Abuse ___ Sickle Cell Anemia
___ Infection with the Human Immunodeficiency Virus (HIV) ___ Mental Health Records

5. I understand that I may revoke this authorization at any time by submitting a written request to the Health Information Management Department of BryanLGH Medical Center, however to the extent that action has already been taken, a revocation will not be possible. Without my permission to revoke this authorization and except as otherwise provided herein, it will automatically expire on the sooner of: after six (6) months from the date of signature, or upon satisfaction of the need for disclosure, or as specified:

6. I understand and agree that BryanLGH Medical Center cannot control the re-disclosure by the recipient of the information disclosed to them, provided, however, that Alcohol, Chemical and Drug Abuse Patient Records which are disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.

7. I hereby release BryanLGH Medical Center from all legal liability that might arise from their release of the information or the re-disclosure of the information by the recipient. I consider a photocopy of this authorization to be as valid as the original.

8. Future treatment or payment will not be conditioned by the signing or not signing of this authorization.

9. I understand that I may upon written request inspect the information to be disclosed.

Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If patient is unable to give authorization, or physically sign, state reason:

Patient or Person Authorized to Consent for Patient/Relationship

Date/Time

Street

City, State, Zip

BryanLGH Medical Center Staff Witness to Signature Only

Person Disclosing Records

BryanLGH Medical Center
Lincoln, NE

**AUTHORIZATION FOR RELEASE
OF MEDICAL INFORMATION**



Place Patient Label Here