

FAMILY EAR, NOSE, & THROAT CLINIC P.C.
6751 North 72nd Street
Suite 207
Omaha Nebraska 68122
402-572-3165 800-634-7013
Fax 402-572-3170

Authorization for Release of Medical Records

Patient Name _____ **Date** _____
Address _____ **SS#** _____
_____ **Birthdate** _____

Receive Records from: _____ **Release Records To:** _____
_____ _____
_____ _____

Please send me a copy of my records as indicated for dates of treatment:

Purpose for releasing medical information.

Signature of Patient, Parent or Legal Guardian **Witness**

Date

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent will also apply to HIV-Aids related diagnoses, sexually transmitted disease and psychiatric disorders/ mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature of Patient **Witness**
Date _____

Permission to fax records for a medical emergency? _____ **Yes** _____ **No**

This authorization expires (90) days from date of signature authorization