R&O RHEUMATOLOGY&OSTEOPOROSIS services p.c.
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CONSENT TO RELEASE INFORMATION

Patient Name____

Address____

DOB_____/_____/_______ Phone Number(_____)_____-______ SSN#______-______-______

I hereby authorize release of medical information
From:____
Name of Person/Agency releasing records

____
Address of Person/Agency releasing records

To: Rheumatology & Osteoporosis Services, P.C.
1520 S 70th St, Ste 200
Lincoln, NE 68506
Phone: 402-464-9000 Fax: 402-464-4447

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****IF MORE THAN 15 PAGES, PLEASE MAIL****

Records to be Released:
___ Office Notes_________________________________
___Medications/Therapy___________________________
___Lab, Pathology, EKG specify type or date ____________
___X-ray reports_________________________________
___Operative report specify type or date ______________
___Other ______________________________________

___**Protected or sensitive information**: I understand that certain information cannot be released without specific authorization as required by State/Federal law. BY INITIALING I authorize the release of the following protected or sensitive information.
____________1) Substance Abuse (alcohol/drugs)
____________2) Mental Health
____________3) HIV-Related Information (AIDS related testing)

▪By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information.
▪You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire 90 days from the date of signing.

_____________________________ _________________ ______________
Signature of Patient/Legal Representative Relationship to Patient Date