

**R&O** RHEUMATOLOGY&OSTEOPOROSIS services p.c.

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Kelsey L. Baxa, APRN

**CONSENT TO RELEASE INFORMATION**

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone Number(\_\_\_\_) \_\_\_\_ - \_\_\_\_ SSN# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I hereby authorize the release of medical information

**From:** Rheumatology & Osteoporosis Services, P.C.  
1520 S 70<sup>th</sup> St, Ste 200  
Lincoln, NE 68506  
Phone: 402-464-9000  
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Kayla Bruss, PA-C  
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**TO:** \_\_\_\_\_  
Name of Person/Agency receiving records

\_\_\_\_\_  
Address of Person/Agency receiving records

**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 1 year from the date of signing.

\_\_\_\_\_  
Signature of Patient/Legal Representative      Relationship to Patient      Date