

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.

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Lincoln, NE 68506
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Fax: 402-464-4447

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Molly Skomer, APRN

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