

R&O RHEUMATOLOGY&OSTEOPOROSIS | services p.c.
1520 South 70th Street, Suite 200
Lincoln, Nebraska 68506
Tel: (402)464-9000 Fax: (402)464-4447
www.rheumatologyandosteoporosis.com

Amy S. Garwood, M.D.
Jennifer R. Elliott, M.D.
Kayla B. Bruss, MPAS, PA-C
Molly B. Skomer, APRN
Kelsey L. Baxa, APRN

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

Amy Garwood, MD
Jennifer Elliott, MD
Kelsey Baxa, APRN

Kayla Bruss, PA-C
Molly Skomer, APRN

****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