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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.

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Lincoln, NE 68506
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Records to be Released: ****IF MORE THAN 15 PAGES, PLEASE MAIL****

___ 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