North Lincoln Family Medical Center

3100 North 14th Street, Suite 201 • Lincoln, NE 68521

CONSENT TO RELEASE INFORMATION

Patient Name ______________________ Other Names Used ______________________

Address ______________________ City ______________ State _____ Zip _________

Phone Number ______________________ Date of Birth ______________________

I hereby authorize:

____
Name of Person/Agency from whom information is requested

____
Address of Person/Agency City State Zip

To release medical information to:

____
Name of Person/Agency Requesting

____
Address of Person/Agency Requesting City State Zip

______________________ ______________________
Signature Date

❑ Individual ❑ Parent (If individual is under 18 years of age) ❑ Legal Guardian

______________________ ______________________
Witness Date

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to: *(check appropriate box below)*

1. Substance abuse (alcohol/drug abuse) ❑ Yes ❑ No ❑ Does Not Apply
2. Mental Health ❑ Yes ❑ No ❑ Does Not Apply
3. HIV-Related Information (AIDS related testing) ❑ Yes ❑ No ❑ Does Not Apply

____
Signature of Patient or Legal Guardian

____ Transfer entire medical record **OR** ____ Specified information listed below

This authorization for release of information shall remain in effect no longer than ninety (90) days.

Please Note: This information may have been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 C.F.R., Part 2) prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

LCMS 1997