COMPLETE CHILDREN'S HEALTH, P.C.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

_____ ___/___/___

Patient Name: Last First MI Date of Birth

The undersigned hereby authorizes:
(Name, address, phone, and fax of Releasing Facility)

_____

_____

_____ _____

_____

To Release Information to:

COMPLETE Children's Health-Medical Records

Phone: 402-465-5600

Fax: 402-327-6092

Faxing is the preferred method to receive records

for the following purpose(s): ☐Moving;☐ Legal Purposes; ☐ Insurance Purposes; ☐ Age _____;

☐ Transfer to other Physician, reason: _____

☐ Other _____

Release the following Health Information: ☐ Entire Medical Record; ☐ Inclusive Dates Only ____/____/____ through ____/____/____ ; ☐ Immunization Records; ☐School Physicals; ☐ Other _____

including, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable line): _____ HIV (AIDS virus), _____ sexually transmitted diseases, _____ mental health, or _____ drug and/or alcohol abuse.

Conditions. We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration. This authorization shall expire upon the earlier of _____/_____/_____ or one year from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation. You have the right to revoke this authorization at any time by notifying the providing organization in writing.

When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Reimbursement. Complete Children's Health, P.C. reserves the right to recover costs involved in producing the requested Health Information. You or the Party to receive disclosure, named above, may be charged $20.00 plus 50 cents per page for handling and copying this information.

By signing below, you acknowledge receipt of a signed copy of this authorization.

_____ _____ _____

Printed Name Date Phone number if questions

_____ _____

Signature Relationship to Patient

Office Use
Provider_____
P.O. _____
Sent By _____