COMPLETE CHILDREN'S HEALTH, P.C.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print request in black ink, include either address or fax number to send records to.

_____ ____/____/____

Patient Name: Last First MI Date of Birth

Release Information From:

Complete Children's Health
Medical Records
Phone: 402-327-6008
Fax: 402-327-6092
***Faxing is preferred method to receive records**

Release Information to:

Name: _____
Address: _____
_____
Phone: _____
FAX: _____

Reason for Release: _____

Release the following Health Information:

☐ Entire Medical Record ☐ Inclusive Dates Only ___/___/___ through ___/___/___

☐ Immunization Records ☐ Other _____

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section titled "Release Information To". I understand that the information to be released may include information regarding Psychological or psychiatric conditions, Drug and Alcohol usage, and AIDS/HIV related information. I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.

Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Reimbursement: Complete Children's Health, P.C. reserves the right to recover costs involved in producing the requested information. You or the recipient of the records may be charged $20 plus 50 cents per page for handling and copying this information.

Patient Age: If the patient is 19 years of age or older, the patient must sign and date the form.

_____ _____ _____
Printed Name Date Phone number if questions

_____ _____
Signature Relationship to Patient