



# Family Health & Wellness Center, P.C.

Comprehensive Health Care for Men, Women and Children

## AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION/RECORDS

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Last First Middle Initial

Sending records to Family Health & Wellness Center, P.C. from another facility	Sending records from Family Health & Wellness Center P.C. to another facility
<b>From:</b>	<b>From: Family Health and Wellness Center, P.C.</b> 6825 S. 27 <sup>th</sup> St., Suite 201 Lincoln, NE 68512 Ph. (402) 434-5235 Fax. (402) 489-2137 Email. info@fhwclnk.com
<b>To: Family Health and Wellness Center, P.C.</b> 6825 S. 27 <sup>th</sup> St., Suite 201 Lincoln, NE 68512 Ph. (402) 434-5235 Fax. (402) 489-2137 Email. info@fhwclnk.com	<b>To:</b>

For treatment dates: \_\_\_\_\_ (specify dates)

### Information to be disclosed:

- \_\_\_ Records from the last \_\_\_ year(s) including progress notes, lab, and ultrasounds
- \_\_\_ Complete medical record including progress notes, lab, and ultrasounds
- \_\_\_ Lab reports, date(s) \_\_\_\_\_
- \_\_\_ OB records, date(s) \_\_\_\_\_
- \_\_\_ U/S reports, date(s) \_\_\_\_\_
- \_\_\_ Progress note(s) \_\_\_\_\_

### For the following purpose:

- \_\_\_ Transfer of Medical Care
- \_\_\_ Insurance
- \_\_\_ Patient request
- \_\_\_ Legal
- \_\_\_ Other (please explain) \_\_\_\_\_

Date needed by: \_\_\_\_\_

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

#### I specifically authorize the release of information relating to: (check all the apply)

- \_\_\_ Substance abuse (including alcohol/drug abuse)
- \_\_\_ HIV/AIDS related information (including test results)
- \_\_\_ Mental Health

I, the undersigned, have read the above, and authorize the disclose of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described may be re-disclosed and no longer protected by those regulations. I understand that the fees may be charged for preparing and sending copies of records, including a charge for labor and supplies of up to \$45.00 per request, a copying charge of \$0.50 per page, and the reasonable cost of all duplications of records that cannot be routinely duplicated on a standard photocopy machine. I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that the action has been taken in reliance upon it or except as otherwise stated in provider's Notice of Privacy Practices by mailing or hand-delivering written notification to the following person: Attn: Office Manager. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

Signature of Patient or Patient's Personal Representative \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/ Legal guardian must sign if patient is a minor: NE - under age 19)

### Relationship to Patient, if not the patient

#### OFFICE USE ONLY:

Received By: \_\_\_\_\_ Date: \_\_\_\_\_  
 To be sent/faxed to # \_\_\_\_\_  To be picked up by/date: \_\_\_\_\_  Picked up on date: \_\_\_\_\_  
 Released by: \_\_\_\_\_  Released to: \_\_\_\_\_