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
From:	**From: Family Health and Wellness Center, P.C.** **6825 S. 27th St., Suite 201** **Lincoln, NE 68512** **Ph. (402) 434-5235** **Fax. (402) 489-2137**
To: Family Health and Wellness Center, P.C. **6825 S. 27th St., Suite 201** **Lincoln, NE 68512** **Ph. (402) 434-5235** **Fax. (402) 489-2137**	**To:**

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: _____
Rev. 7/2018 – VD