AUTHORIZATION FOR USE and/or DISCLOSURE
of
PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

Name of Patient: _____ Date of Birth: _____ SS#: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Phone Number: Home: _____ Cell: _____ Work: _____

I authorize the release of my Protected Health Information between the following entities:

Circle selection: TO *or* FROM

Capital Medical Clinic, LLP
4701 Normal Blvd.
Lincoln, NE. 68506
Phone (402) 488-5050 Fax (402) 488-5001

Circle selection: TO *or* FROM

_____
Name of Doctor/Facility

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number Fax Number

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed:*
□ Complete Medical Record
□ Other: _____

FOR THE FOLLOWING DATES: From: _____ To: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (please check all that apply)

□ HIV/AIDS related testing and results □ Mental/Behavioral Health Conditions □ Chemical Dependency (Drug/Alcohol Abuse)

Signature: _____ Date: _____

There is a cost-based charge for copying records as follows:
- *No charge for records being sent to another provider*
- *Records Mailed: $20.00 processing fee plus $.10 per page*
- *Records copied to a disk: $20.00 processing fee*

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*
□ Continuing Care □ Transfer to New Provider □ Insurance/Claim Purposes □ Legal □ Personal Use □ Disability Determination
□ Workers Compensation □ Other: _____

_____ _____
SIGNATURE OF PATIENT/LEGAL REP **DATE**

_____ _____
If signed by Personal Representative, Print Name Relationship to Patient

_____ _____ _____
Power of Attorney – Print Name **Signature** **Date**
(Please provide *Capital Medical Clinic, LLP* with a copy of the POA)