

# CAPITAL MEDICAL CLINIC, LLP

4701 NORMAL BLVD, LINCOLN, NE 68506

Phone: 402 488-5050 Fax: 402 488-5001

Lisa M. Peterson, MD  
Uma Nooka, MD

Mary L. Drey, MD  
Gary Van Ert, MD

Heather Farwell, PA-C  
Teresa Novak, PA-C

## Authorization to Release Private Health Information (PHI)

I hereby authorize Capital Medical Clinic to release my PHI (private health information) to the following people. This authorization will remain in effect until I complete a new Authorization to Release PHI form.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

Name \_\_\_\_\_ relationship \_\_\_\_\_

Name \_\_\_\_\_ relationship \_\_\_\_\_

Name \_\_\_\_\_ relationship \_\_\_\_\_

Name \_\_\_\_\_ relationship \_\_\_\_\_

Name \_\_\_\_\_ relationship \_\_\_\_\_

### Privacy Protection:

OK to call you at work?	Y	N	N/A
OK to speak to your spouse about medical and billing information?	Y	N	N/A
OK to leave medical and billing information on your home voice mail?	Y	N	N/A
OK to leave medical and billing information on your cell phone voice mail?	Y	N	N/A
Do you have a POA (Power of Attorney) ?	Y	N	N/A

If Yes please list POA contact information:

Name (First/Last): \_\_\_\_\_

Address: \_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
Patient signature, signature of parent/guardian of minor patient or POA (Date)

\_\_\_\_\_  
Please print your name (please use your legal name or the name on your insurance card) Relationship to patient

