



O F G R A N D I S L A N D

820 North Alpha Street ■ Post Office Box 5226 ■ Grand Island, NE 68802
Phone 308-384-7200 ■ 800-652-3754 ■ Fax 308-384-7378

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Patient's Name: _____ Maiden Name: _____

Date of Birth: _____ SSN: _____

I request and authorize disclosure of protected health information on the patient named above:

FROM: Doctor: _____ TO: Doctor: _____

Clinic Name: _____ Clinic Name: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

I hereby request you to release the following information from my medical record:

Complete medical record, including mental health, substance abuse, or HIV / AIDS information.
Note: We will send the first set of records free of charge. There will be a \$20.00 plus \$.50 per page charge for each additional copy.

Specific medical records relating to the following condition, surgery, or date(s) of treatment: _____

This information has been disclosed to the above named party from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits further disclosure of this information without specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. I understand that the information to be released may include information regarding mental health, alcohol or drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected.

Disclosure Purpose: ___ Medical Care ___ Personal Info ___ At the request of the individual
___ Work Comp Carrier ___ Insurance ___ Other: _____

Signature: _____ Date: _____

If the signature is by a personal representative of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: ___ Parent ___ Legal Guardian* ___ Power of Attorney*

* Please attach legal documentation if you are the Legal Guardian or Power of Attorney

This authorization expires six (6) months after the date of signature. However, this authorization may be revoked at any time during these six (6) months, through written notice to Surgery Group of Grand Island, if received prior to the disclosure of Protected Health Information (PHI). I understand that this authorization is voluntary and my healthcare will not be affected.

For office use only

Date Needed: _____ Copied By: _____

Picked up _____ Mailed _____ Faxed _____ Date Sent/Picked up: _____