Gastroenterology Specialties P.C. Lincoln Endoscopy Center, L.L.C.

4545 R Street Ste 100, Lincoln, NE 68503 402-465-4545 FAX: 402-465-9011

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME_____
Last First Middle Maiden or other name

Date of Birth: _____-_____-_____ SS#_____-_____-_____ Medical Record #: _____
Month Day Year

_____
Address City, State, Zip

(_____)_____
Area Code Phone

REQUEST I hereby authorize Gastroenterology Specialties, PC and Lincoln Endoscopy Center, LLC to:
□ Disclose To □ Obtain From

_____
Organization or Physician Telephone Number Fax Number

_____
Address City, State, Zip

MEDICAL RECORDS	**DATES**
□ History and physical exam	_____
□ Chart/Clinic Notes	_____
□ Lab reports	_____
□ X-ray reports	_____
□ EKG	_____
□ Complete records	_____
□ Other_____	

PRIVACY
I specifically authorize the release of information relating to:
□ Substance abuse (including alcohol/drug use)
□ Mental health (including psychotherapy notes)
□ HIV related information (AIDS related testing)
□ Research

PURPOSE OF DISCLOSURE			
□ Referral	□ Appointment Date_____	□ Continuing Care Elsewhere	□ Personal
□ School	□ Workers Compensation	□ Changing physicians	□ Legal
□ Other (please specify):_____	□ Moving Out of Town	□ Research Purposes	□ Insurance

AUTHORIZATION
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Gastroenterology Specialties/Lincoln Endoscopy Center. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date_____. If I fail to specify an expiration date, this authorization will expire one year after I have signed the form. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or receive a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer of Gastroenterology Specialties/Lincoln Endoscopy Center. I understand I may be given a copy of this form by request.

_____
Patient Signature Date
OR

_____
Signature of Parent/Legal Guardian/Authorized Person Date

_____
Records Received by Whom/Date/Relationship to Patient
Photo ID checked to verify the identity. _____ Staff member initialed as done.

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____
BY: _____