Fallbrook Family Health Center

755 FALLBROOK BLVD
SUITE 100
LINCOLN, NE 68521-9056

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Authorization for
RELEASE OF HEALTH INFORMATION

Please note: If any section is incomplete, this form becomes invalid.

Patient:	Name:		
	Address:		
	City:	State:	Zip:
	Date of birth:	Phone:	

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

Circle Selection: **TO or FROM**	***Circle Selection:*** **TO or FROM**
Fallbrook Family Health Center	_____
755 Fallbrook Blvd., Suite 100	_____
Lincoln, NE 68521	_____

Health Information To Be Disclosed	**Please Note: If dates are not provided, only the past two years will be provided.**			
	☐ Copies of Clinical Notes	From (date):	From (date):	
	☐ Copies of Hospital Records	From (date):	From (date):	
	☐ Laboratory Records	From (date):	From (date):	
	☐ Radiology Reports	From (date):	From (date):	
	☐ HIV/AIDS Testing/Treatment	From (date):	From (date):	
	☐ Alcohol/Drug Abuse Evaluation	From (date):	From (date):	
	☐ Other _____			
	☐ ALL of the above / OTHER	From (date):	To (date):	
Reason for Request	☐ Consult/Second opinion	☐ Disability	☐ Legal	☐ Personal
	☐ Change of Doctor	☐ Continuity of Care Only		☐ Other
Revocation	I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. **I understand that this authorization will be in effect for 90 days from the date signed unless revoked by me in writing.**			
Authorization	I understand that authorizing the release of this information is voluntary, I understand that I may have access to my health information. I understand that any release of information carriers wth it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that Fallbrook Family Health Center is not responsible for electronic or paper records re-disclosure once the records have been released to the patient or facility. **Please allow up to 30 days to process this release.** **Copying fee: $20 + .50 per page may apply. (personal and legal reasons)**			
	Patient Signature (Age 19 & older must sign or legal guardian)	Date:		
	Relationship to patient/Authority	Date:		