Fallbrook Family Health Center
755 Fallbrook Blvd., Suite 100
Lincoln, NE 68521
P. (402) 441-3575 F. (402) 438-2107

I, _____, give permission to Fallbrook Family Health Center to disclose and release my protected health information described below to:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (check all that apply):

- □ My complete health record (including by not limited to diagnosis, lab tests, prognosis, treatment, and billing, for all conditions) OR
- □ My complete health record, as above, with the exception of the following information:
  - □ Mental health records
  - □ Substance Abuse (Drug/alcohol abuse/treatment)
  - □ HIV and AIDS related testing
  - □ Other (please specify)_____

This health information may be used to enable the person I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- □ All past, present, and future periods, OR
- □ Date or event: _____
  Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

Patient Name (printed):_____ Patient DOB:_____

Patient Phone Number:_____

Patient Signature:_____ Date:_____