Privacy Request: Authorization for Disclosure of Protected Health Information

LINCOLN NEPHROLOGY & HYPERTENSION PC

7401 O Street, Lincoln, NE 68510 | 402-484-5600 | Fax: 402-484-5630 | lincolnnephrology.com

Patient Name: _____

Date of Birth: _____ Telephone: _____ _

Address: _____

_____

I authorize _____ to disclose the following information from my health records to:

Person/Entity receiving information: _____

Purpose of disclosure of information: _____

Information to be disclosed:

- □ Complete copy of medical records
- □ Other (please specify) _____

The information authorized for disclosure may relate to: (check if applicable)

- □ Acquired immunodeficiency syndrome (AIDS)
- □ Human immunodeficiency virus (HIV)
- □ Alcohol or drug treatment
- □ Mental illness (excluding psychotherapy)

I understand that this authorization will not expire but may be revised or revoked in writing at any time upon delivery to Lincoln Nephrology and Hypertension; this revocation will not be effective to the extent that Lincoln Nephrology and Hypertension has relied on my authorization to disclose protected health information up to the time of receiving revocation.

I understand that Lincoln Nephrology and Hypertension will not conditiion treatment on my signing this authorization.

I understand the information used or disclosed based on this authorization may not be protected from further disclosure by the recipient of the information.

_____ _____

Date Signature of patient/representative

_____

Authority or relationship of representative