Doctors of Children
6041 Village Drive, Suite 150, Lincoln, NE 68516
Phone: (402) 423-1900 Fax: (402) 423-5991

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I specifically authorize Doctors of Children to use and/or disclose certain protected health information (PHI)

Patient Name: _____ **Date of Birth**: _____
Patient Name: _____ **Date of Birth**: _____
Patient Name: _____ **Date of Birth**: _____
Patient Name: _____ **Date of Birth**: _____

Patient's Address: _____

Patient's Phone #: _____

Authorize Information Released From: **Please Send My Records To:**

Doctors of Children, Lincoln PC _____
6041 Village Dr., Ste 150 _____
Lincoln, NE 68516 _____

Specific description of information (including dates):

_____

Purpose of the use or disclosure: __ At the request of the individual __Insurance not accepted by DOC __Changing Doctor __Moving __Physician or Staff Request __Other _____

I understand that I may revoke this authorization at any time by sending a written request to the Practice – Attn: Privacy Officer. However, the revocation will not have any effect on uses or disclosures the Practice may have made before the revocation was received.

I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) months after the date this authorization is signed.

Doctors of Children, Lincoln PC and its employees, officers and physicians are hereby released from any and all legal responsibility or liability as to any disclosure of any documents generated by any healthcare provider other than Doctors of Children, Lincoln PC. Doctors of Children, Lincoln PC does not attest to, warrant nor guarantee the accuracy of completeness of documents from other healthcare providers.

Nebraska State Law allows 30 days from the date the release is received to transfer medical records.

There is a fee of $20.00 + $.50 per page for copying of medical records for personal use (legal, insurance, etc); one time no charge for medical purposes.

I certify that I am (check which applies):
__the patient (must be 19 or older)
__the patient's authorized representative (for patient under 19 years of age)
My relationship to the patient is that of _____

Signature: _____ Date: _____

If signature is not that of patient: Print Name: _____
Address: _____
_____
Phone #: _____

****A copy of this Authorization Should Be Retained by the Patient ****
Revised 8-25-14