Nebraska Urban Indian Medical Center
2331 Fairfield Street, Suite 1
Lincoln, NE 68521
Phone: 402-434-7177
Fax: 402-434-7176

Release of Information

Patient Information

Patient Name: _____ **Previous Name:** _____

Date of Birth: _____ **SS#** _____ **Phone:** _____

Address: _____ **City/State/Zip:** _____

Authorization

____ To release records to ____ To receive records from ____ To Exchange records **To and From**

Provider/Institution Name: _____

Address: _____ **City/State/ Zip:** _____

Phone: _____ **Fax:** _____

____ All my health information _____ Specific dates of service: _____ Specific service: _____

Specific authorization for Release of Information protected by State or Federal Law

_____ Mental Health testing, counseling and treatment information _____ HIV/AIDS/STD

_____ Chemical Dependency (drug and alcohol) ___ Other: _____

For Purpose of: ____Continuity of Care ____Transfer of Care ____Other: _____

This authorization is effective for one year from the date on which it was signed. I understand once our office discloses health information, the organization or person that receives it may be able to redisclose it. Privacy laws may no longer protect it. There is no guarantee preventing re-disclosure. The federal rule prohibits from making any further disclosure of this information unless further disclosure is permitted (42CFR Part 2).

Signature of patient or legal guardian: _____ **Date:** _____

Printed Name: _____ **Relation to Patient:** _____