AUTHORIZATION FOR REQUEST OR RELEASE OF MEDICAL INFORMATION

4740 A Street, Suite 100 | Lincoln, NE 68510-4893 | Phone: 402.483.7825 | Fax: 402.483.7839

(PLEASE PRINT)

Patient's Legal Name: ______________________________

Patient's Nickname: ____________________ **Age:** ________ **Birthdate:** ____/____/____

Address: ______________________________

City, State, Zip Code: ____________________ **Phone #:** (   ) __________

Records to Request or Release:

____ Complete Record
____ Emergency Room Record
____ History and Physical Examination
____ Consultation Report
____ Progress Notes
____ Discharge Summary
____ Operative Report

Date(s) of Service: ____/____/____

____ Lab and X-ray Report
____ Doppler Report
____ Cath/PTCA Report
____ X-ray Films
____ Cine Films
____ Other (specify)
____
____
____
____
____

Reason for Release:

____ To update my Primary Care Provider
____ I have been referred to another physician
____ I want/need a second opinion
____ I am changing doctors due to:
  ____ Insurance change
  ____ Dissatisfaction with care
  ____ Moving to a new address
  ____
  ____
  ____
____ Other ____________________

I understand that Lincoln Surgical Group, P.C. **may refuse health care services** to me if I fail to sign an authorization if the treatment is for research purposes. I understand that **I may revoke** this authorization at any time, except to the extent that **action has already been taken** to comply with it, by following the procedures provided for in Lincoln Surgical Group's Notice of Privacy Practices. This authorization will **automatically expire** after six (6) months from the date it is signed.

REQUEST FROM

This authorization gives my permission and consent to **REQUEST** from the following described facility,those medical records and test results checked above regarding medical treatment and care that I have received at such facility:

Facility Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: (   ) __________ Fax: (   ) __________

Mail or Fax to:
Lincoln Surgical Group, P.C.
4740 A Street, Suite 100 | Lincoln, NE 68510-4893
Fax: 402-483-7839

RELEASE TO

This authorization gives my permission and consent to **RELEASE** those medical records and test results checked above regarding medical treatment and care that I have received from Lincoln Surgical Group, P.C. to the following:

Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Phone: (   ) __________ Fax: (   ) __________

I understand that Lincoln Surgical Group, P.C. is not responsible for uses or disclosures of my medical information by the above party and that there is the potential for such party to further disclose my medical information in a way that it would no longer be protected by privacy laws.

____
Date

____
Signature of Patient or Authorized Representative

____
Physician's Signature of Consent

Date Completed: ____/____/____