AUTHORIZATION FOR REQUEST OR RELEASE OF MEDICAL INFORMATION

Lincoln Surgical
GROUP, P.C.

575 S 70th Street, Suite 405 | Lincoln, NE 68510-2471 | 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:

___ Most Recent Office Note
___ Emergency Room Record
___ History and Physical Examination
___ Consultation Report
___ Progress Notes
___ Discharge Summary
___ Operative Report
___ Lab Report
___ Doppler Report
___ Pathology Report

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

___ CT Scan
 ___ Report
 ___ CD
 ___ Films
___ Ultrasound
 ___ Report
 ___ CD
 ___ Films
___ PET Scan
 ___ Report
 ___ CD
 ___ Films

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.**
575 S 70th Street, Suite 405 | Lincoln, NE 68510-2471
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: ___/___/___