

I hereby authorize \_\_\_\_\_  
Name of Physician or Facility

Address \_\_\_\_\_  
Street # and Name Apt/Unit # City, State, Zip

to disclose the health information as follows.

**Disclose to:** University Health Center, Medical Records, PO Box 880618, Lincoln, NE 68588-0618  
Recipient Name and Mailing Address

**Phone #** 402-472-7420

I understand that this authorization is voluntary. I understand that the information could be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

**Patient Name** \_\_\_\_\_ # \_\_\_\_\_  
Please PRINT (first name, middle initial, last name) Last 4 digits SS #

**Birth Date** \_\_\_\_\_ **Other Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Address** \_\_\_\_\_  
Street # and Name Apt/Unit # City, State, Zip

**Purpose(s) of Disclosure:** Continuity of Care Other \_\_\_\_\_

Covering records for the period from \_\_\_\_\_ to \_\_\_\_\_

**The foregoing is subject to such limitations as indicated below: (Check at least one)**

<input type="checkbox"/> Clinic Records	<input type="checkbox"/> Laboratory Report(s)	<input type="checkbox"/> Radiology Report(s)
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Allergy	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Other _____	<input type="checkbox"/> No Limitations	

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION**

I specifically authorize the release of data and information relating to: (check appropriate box below)

1. Substance Abuse (alcohol/drug abuse)	YES	NO	DOES	NOT APPLY
2. Mental Health (includes psychological testing)	YES	NO	DOES	NOT APPLY
3. HIV-Related Information (AIDS-related testing)	YES	NO	DOES	NOT APPLY

I understand that I may revoke this consent at any time; revocation is not retroactive to release of medical information released in good faith.

Upon fulfillment of the above-stated purpose or the lapse of 90 days from the date of signature, whichever comes first, this consent will automatically expire without my revocation.

I understand that the Health Center and its employees, and my attending provider and his/her associates, who participated in my care cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this notification, and hereby release them from any liability arising from such disclosure.

My refusal to sign this authorization will not affect my ability to obtain treatment at the University Health Center.

Signature of Patient or Authorized Representative \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Relationship if Authorized Representative \_\_\_\_\_ Check if disclosure is at the request of the patient. \_\_\_\_\_

**A COPY OF THIS AUTHORIZATION WILL BE VALID AS ORIGINAL**