Gage County Medical Clinic

A Beatrice Community Hospital and Health Center Physician Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION FROM AN OUTSIDE ENTITY

Mailing Address: 1101 North 10th
Beatrice, NE 68310

Phone (402) 228-3436
Fax (402) 223-4515

Instructions:
Please complete this entire form to request copies of personal health information from an outside institution, clinic, physician, etc. for continuing medical care.

1. **Patient Name** _____ **Birth date** _____

   Current Address _____ **Daytime Telephone** _____

2. **I hereby authorize and request release of my medical records:**
   FROM: _____
   (Name of individual to receive information)
   _____
   (Street Address)
   _____
   (City) (State) (Zip)

   TO: _____
   (Name of individual to receive information)
   _____
   (Street Address)
   _____
   (City) (State) (Zip)

3. **Information to be disclosed:**
   From (date)_____**to (date)**_____

   ☐ **Discharge Summary Including Medication Reconciliation**
   ☐ **History and Physical Examination**
   ☐ **Operative Report**
   ☐ **Pathology Report**
   ☐ **Laboratory Results**
   ☐ **All records**
   ☐ **EKG/EEG Reports**
   ☐ **Clinic Notes**
   ☐ **Emergency Room Record**
   ☐ **Drug and Alcohol**
   ☐ **Psychiatric/Mental Health**
   ☐ **Physical/Occupational/Speech Therapy Notes**
   ☐ **Prenatal (Pregnancy) Records**
   ☐ **Radiology Images**
   ☐ **Imaging Reports**
   ☐ **Billing record**
   ☐ **STD's (Sexually Transmitted Disease)**
   ☐ **Other (Please specify)** _____
   _____

4. **This statement of consent can be revoked at any time before disclosure of the information, and expires on** _____ **(expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 365 days after it is signed.**

   I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

   I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

_____ _____
(Signature of patient) **(Signature of parent, guardian, or Authorized representative)**

_____ _____
(Date) **(Relationship of above person to patient)**