WAVERLY Health Care
URGENTCARE

Authorization for the Release of Medical Information / Medical Records

Patient Name:_____ **Date of Birth:**_____/_____/_____
Last **First** **Middle initial**

□ **Sending records to Waverly Health Care; please check this box & fill out the boxes below**	□ **Sending records to another facility; please check this box & fill out the boxes below**
From: _____ _____ _____	From: Waverly Health Care Urgent Care 3901 Pine Lake Rd Suite 211 Lincoln NE 68516
To: Waverly Health Care Urgent Care 3901 Pine Lake Rd Suite 211 Lincoln NE 68516 Phone: 402-423-4200 Fax: 402-423-4201	To: _____ _____ _____

Please send the following health information:
__ Entire Medical Records __ Inclusive Dates Only ___/___/_____-___/___/_____
__ Immunization Records __ Mental Health Records __School Physicals
__ Other; including, if applicable, the following health information related to testing, diagnosis, and or treatment for (please initial if applicable):_____ HIV (AIDS virus) _____sexually transmitted disease _____mental health _____ or drug and or alcohol abuse.

Information to omit:

__ Mental Health records __ HIV/AIDS records __ Substance abuse (Drugs/Alcohol) records

__ Other:_____

If leaving practice, please provide us with the following (check all that apply):
___Moving ___Legal Purposes ___Insurance purposes ___Personal
___Transfer to new physician; reason_____

The date of this authorization is ____ / ____ / _____ and shall remain in effect until ____ /____ / _____ (if no ending date is given, it shall remain in effect for on year from the date of authorization).

Conditions: We may not condition your right to receive health care services from us upon your signing of this authorization if you are leaving our practice. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent is from providing such treatment.

Further use and disclosures: When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such situation, your disclosed health information may no longer be protected by federal and state laws.

Revocation: You have the right to revoke this authorization at any time by notifying the providing organization in wiring. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Reimbursement: Pine Lake Health, LLC reserves the right to recover the cost involved in producing the requested health information. You or the party to receive disclosures, named able, may be charges $20.00 plus 50 cents per page for handling and coping this information.

I authorize the use and disclosure of the medical records and health care information indicated above:

Print Name:_____ **Date:** ____/ ____ / _____

Patient Signature:_____

Relationship to patient: **self** **or** _____

For office use only;
Acct $:_____
Initials:_____