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 Omaha, NE 68114
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Patient Label

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize Children's Nebraska to release the following information:

Patient Name _____ Date of Birth _____

Address _____ Telephone _____ City _____

_____ State _____ Zip Code _____

Dates of Service: From (date) _____ To (date) _____

Information to be released:

Hospital Records

- Primary Documents-Physician Reports/Diagnostic Tests
- OR**
- Emergency/Urgent Care
- Report Discharge Summary
- Radiology Report
- Lab Tests
- Immunizations
- Patient Condition (for release to media)
- Other _____

Specialty Pediatric Center Records

- Primary Documents-Physician Reports/Diagnostic Tests
- OR**
- Lab Tests
- Radiology Reports
- Other _____
- Immunizations
- Specific Physician/Clinic: _____

Children's Physician Records

- Primary Documents-Physician Reports/Diagnostic Tests
- OR**
- Lab Tests
- Radiology Reports
- Other _____
- Immunizations
- Specific Physician/Clinic: _____

Children's Home Health Records

- Primary Documents-Physician Reports/Diagnostic Tests
- OR**
- Lab Tests
- Radiology Reports
- Other _____

This information is to be disclosed to (Name & Address):

Method of Delivery:

- Record will be picked up (will call when ready)
- Record to be sent via 1st class mail* to address at left via (please check one):
 - Paper Format
 - CD Format (Unencrypted)
 - CD Format (Encrypted-will require WinZip)
 - Email (Encrypted) _____

*Children's Nebraska is not responsible for copies of records once they have been mailed.

Purpose of information to be disclosed: _____

To the extent allowed under HIPAA, I also authorize release of information relating to (initial if applicable):

- _____ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection
- _____ Behavioral Health Services/Psychiatric Care
- _____ Eating Disorder Clinic Records

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. I further understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state confidentiality regulations. Unless otherwise revoked, this authorization will expire on the earlier of the identified date below or 12 months from date of signature. Children's will not condition treatment on the provision of this authorization.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please note that it is the practice of Children's Nebraska to only release information created by this facility and not re-disclose information created elsewhere.

Signed _____ Date _____
 (Patient or Legal Representative) (Relationship to Patient)

Printed Name: _____

Date of Expiration: _____

Please Complete this Box Before Sending to HIM

____ Records need to be released by HIM

____ Records have been released (check one below)

____ Verbal ____ Faxed ____ Mailed ____ In-person

Name: _____ Date: _____