NEBRASKA PULMONARY SPECIALTIES

www.nepulmonaryspecialties.com
1500 S 48th St, Suite 800
Lincoln, NE 68506
16909 Lakeside Hills Ct, Ste 410, Omaha NE 68130
Phone: (402)483-8600
Fax: (402)483-8689

Patient Authorization for Use and Disclosure of Protected Health Information

_____ _____
PATIENT'S FULL NAME (include maiden name if different) Date of Birth

Please release my information TO the following:

Name(s): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This authorization covers the following individually identifiable health information about me:

[ ] A summary of my medical history and an overview of my visits, including my diagnoses, between and including the date (s) _____ to _____ or; [ ] all dates.

[ ] Medical testing reports or discs and correspondence regarding _____ between and including the date(s) _____ to _____ or; [ ] all dates.

[ ] Other (specifically describe, such as date (s) of services, type of services, level of detail to be released, origin of information, etc.): _____

Reason for use or disclosure:_____

This authorization will expire one year from date of signed release.

I understand that if this authorization is used to transfer copies of my records to a new physician at my request, only a summary of my medical history and an overview of my visits as described above will be sent. If more detailed information is deemed necessary for proper continuation of treatment by the physician sending or receiving this information, it will be sent without any further authorization from me, unless I have objected to this in writing. When my information is used or disclosed under this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Nebraska Pulmonary Specialties, LLC has acted in reliance upon this authorization. My written revocation or objection must be submitted to the Privacy Office at: 1500 S. 48th St. Suite 800, Lincoln, NE 68506.

Signed by: _____ _____
Signature of patient or legal guardian Relationship to patient

_____ _____
Print name of patient or legal guardian Date