Complete Rural
Medicine
515 2ND STREET, FRIEND, NE 68359
3900 S 6th Street, Suite 1, Lincoln, NE 68502
PH: 308-646-2471 FAX: 308-663-3336

Authorization to Release Health Information

Patient name _____ DOB _____ Phone # _____

Address _____

Primary Care Provider: _____

I authorize Complete Rural Medicine to: _____ Give Health Information TO OR _____ Get Health Information From

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(Name Person or Place to give the records OR to get the records from) Phone #

_____

Address Fax #

Purpose of Disclosure: _____ Transfer of Care _____ Personal Record _____ FMLA * _____ Disability *_____ Other _____

* If FMLA or Short Term Disability Specify Dates absent from Work and Reason for absence: _____

(Dates)

(Reasons for Absence)

Information to be Disclosed:
_____ H&P _____ ER Record _____ Office/Clinic Notes _____ Lab Reports _____ Progress Notes _____ Discharge Report
_____ X-Ray Reports _____ Immunization Record _____ Complete Record _____ Specialty Clinic Record _____ Other: _____

I Specifically authorize the release of information relating to:
_____ Substance abuse (including drug/alcohol abuse)
_____ Mental Health
_____ HIV/AIDS related information (including test results)

Date(s) of Service: _____
(State: specify dates, time period or "ALL"

I understand that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Complete Rural Medicine.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal Law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to he Health Information Director. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) this document and this disclosure is at my request.
5. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Patient signature or Legal Representative signature and their relationship to patient Date

_____ _____
Witness Date

_____ _____
2nd Witness required for phone authorization Date

Date received:
Date record sent:
☐Fax ☐ Mailed ☐Picked Up
MR#:_____

Note: This facility, its employees and officers and attending physicians are released from the legal responsibility or liability for the release of the above information to the extent indicated and authorized.

* Complete Rural Medicine, LLC may charge standard applicable fees for processing and furnishing information. Patient will be notified. **