Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St, Lincoln NE 68506 | Phone: (402) 423-4200 | Fax: (402) 423-4201 | Email: info@pinelakehealth.com

Authorization for the Release of Medical Information / Medical Records

Patient Name: _____ Date of Birth: ____/_____/_____
Last First MI

TO or FROM (circle one) :	**TO:**
_____ **(Name of facility or Medical Provider)**	**Pine Lake Health / Waverly Health Care**
_____ **(Address)**	2611 S. 70th St, Lincoln NE 68506 OR 13220 Callum Dr. Suite 4, Waverly NE 68462 (**do not send records to the Waverly address**)
_____ **(Address)**	**Fax: 402-423-4201** (*Please DO NOT fax more than 10 pages! Records over 10 pages, please send via secure email or place on CD & mail to our address*)
_____ **(Phone & Fax)**	

Please send the following health information:

____ Entire Medical Records ____ Inclusive Dates Only ___/___/_____-___/___/_____

____ Immunization Records ____School Physicals ____ Mental Health Records

____ Other; if applicable, the following health information related to testing, diagnosis, and or treatment for:

_____ HIV/AIDS virus _____sexually transmitted disease _____mental health _____ drug and/or alcohol abuse.

Information to omit: State and Federal law protect the following information as directed by you, the patient.

____ 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):

____Referral to/from another medical office ____Moving/Moved ____Legal Purposes
____Insurance Purposes ____Personal ____Other:_____
____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 one 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 us 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 writing. 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 _____