Nebraska Medicine

Patient Information Sticker

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Birth Date: _____

Address: _____ Telephone: _____

_____

I hereby authorize and request release of my medical records from:

Institution/Provider: _____

Medical Records are to be sent to:

Liver / Intestinal Failure Program
Digestive Diseases & Kidney Clinical Program
Nebraska Medicine
983285 Nebraska Medical Center
Omaha, NE 68198-3285
Phone: (402) 559-5000 • Toll Free: 1-(800) 401-4444 • Fax: (402) 559-8902

Information to be disclosed:

- ☐ Discharge Summary x 1 year
- ☐ History & Physical Exams x 1 year
- ☐ Operative Reports x 1 year
- ☐ Pathology Reports x 5 years
- ☐ Laboratory Reports x 6 months
- ☐ Cardiology Studies x 1 year
- ☐ Dialysis Records (last 3 months)
- ☐ EKG Report (most recent)
- ☐ Clinic Notes x 1 year
- ☐ Psychiatric Information x 1 year
- ☐ X-Ray Reports x 2 years
- ☐ Other (please specify below)

Specify: _____

_____

Purpose of Release: ☐ Medical Care ☐ Personal Records ☐ Attorney
☐ Other (please specify): _____

This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, six months after it is signed.

Date of Expiration: _____/_____/_____

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by Federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations.

_____ _____
Signature of Patient Signature of Parent, Guardian or Authorized Representative

_____ _____
Date Relationship of Above Person to Patient