Authorization to Use and Disclose Protected Health Information
Mary Lanning Specialty Clinics

Mary Lanning HEALTHCARE

❑ **Attention: Health Information Management (HIM)** **MRN:**_____

Mailing Address: 715 N. St. Joseph Ave., Hastings, NE 68901 **Fax #:** 402-461-5311 **Phone #:** 402-461-5174

HASTINGS PULMONARY & SLEEP CLINIC
715 N. Kansas Ave., Suite 101
Hastings, Nebraska 68901
Phone: 402-460-5787
Fax: 402-460-5794

HASTINGS ORTHOPAEDICS
715 N. Kansas Ave., Suite 106
Hastings, NE 68901
Phone: 402-462-2139
Fax: 402-462-2381

CENTRAL NEBRASKA CHILDREN & ADOLESCENT CLINIC
2115 N. Kansas Ave., Suite 103
Hastings, NE 68901
Phone: 402-463 6828
Fax: 402-463-4767

CENTRAL NEBRASKA GENERAL SURGERY
715 N. Kansas Ave., Suite 107A
Hastings, Nebraska 68901
Phone: 402-461-5261
Fax: 402-461-5216

CENTRAL NEBRASKA KIDNEY CARE
715 N. Kansas Ave., Suite 107B
Hastings, NE 68901
Phone: 402-460-5567
Fax: 402-460-5568

CENTRAL NEBRASKA PLASTIC & RECONSTRUCTIVE SURGERY
715 N. Kansas Ave., Suite 107C
Hastings, Nebraska 68901
Phone: 402-460-2561
Fax: 402-460-4505

1. Patient Name:_____ Date of Birth:_____

Address:_____

Phone #:_____ SSN:_____ Driver License #:_____
(optional or last 4 digits)

2. I hereby authorize and request release of my medical records

From:_____

_____

Phone #:_____ Fax #:_____

To: _____

_____

Phone #:_____ Fax #:_____

3. Information to be disclosed:

Starting Date:_____ **Ending Date:**_____

Type of Information to be disclosed:

❑ Demographic ❑ Financial Record ❑ History and Physical Exam ❑ Lab
❑ Office Notes ❑ Pathology Reports ❑ Radiology Reports ❑ Verbal Communication
❑ Other (Specify):_____

****Disclosure Format:**

❑ Patient Portal ❑ Mail ❑ Pick Up ❑ Fax #:_____
❑ Encrypted Email ❑ *Unencrypted Email Email address:_____

**Note: If selecting Unencrypted email, I understand the risk in receiving my PHI this way and that it may be read by a third party.*
***Fees: I understand that there may be a fee charged for the copying of medical records*

4. Purpose of Disclosure:

❑ Insurance / Payers ❑ Legal Proceedings ❑ Personal ❑ Treatment
❑ Other (specify)_____

5. I understand that the information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to his authorization. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless previously revoked, this authorization will expire one year from date of signature or _____. I consider a photocopy of this authorization to be as valid as the original. My refusal to sign this authorization will not affect my ability to obtain treatment at Mary Lanning Healthcare. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules.

_____ _____
Signature of Patient Signature of Legal Representative

_____ _____
Relationship of Legal Representative to Patient Date