SOUTHWEST FAMILY PHYSICIANS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____

City / State / Zip: _____

Phone #: _____

Maiden or Prior Names: _____

Information to be released: _____ ALL Medical Records

_____ Specific Information: _____

Pleases release my healthcare information from:

Facility: _____

Provider: _____

Address: _____

City / State / Zip: _____

Phone #: _____

Fax #: _____

Please send my healthcare information to:

SOUTHWEST FAMILY PHYSICIANS

8258 Hascall St

Omaha, NE 68124

Phone: (402) 391-3010

Fax: (402) 391-3076

Purpose of disclosure:

_____ Personal Use

_____ Transferring Care

_____ Legal

_____ Other

Signing this authorization is NOT a condition of treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility of benefits on my signing this authorization. I understand that this is an authorization for disclosure to a third party under the guidelines of the HIPAA privacy practices.

Individuals patient's signature

I have had the chance to read and think about the content of this authorization form and I agree with all the statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of protected health information with the people and/or organizations named in this form. I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before the receipt of my written notice to revoke this authorization.

Signature: _____ Date: _____

This authorization will expire 90 days for the date signed above

If this authorization is signed by a personal representative or on behalf of a minor:

Parent or personal representative

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

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