Joshua Medical Centers

2429 M St Omaha, Ne 68107

402-731-7333/402-614-5405 Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

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

From: _____

(Healthcare facility to send information)

To: _____

(Name of Institution or Individual to receive information)

_____

(Address) **(City)** **(State)** **(Zip Code)**

Information to be Disclosed:

From (Date): _____ to (Date); _____

☐ Discharge Summary ☐EKG/EEG Reports

☐History and Physical Examination ☐ Emergency Room Records

☐Operative Report ☐Clinic Notes

☐Pathology Reports ☐ Psychiatric Reports

☐ Laboratory Reports ☐ Physical/Occupational Therapy Notes

☐ X-Ray/Imaging Reports ☐ Prenatal Records

☐ Other (Please Specify) _____

_____

Expiration Date of Authorization

This authorization is effective through _____/_____/_____ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to (Name of Practice). You should contact the (Title of Privacy/Compliance Officer) to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The Privacy of this information may not be protected under the federal privacy regulations.

_____ _____

(Signature of Patient) (Signature of Parent,Guardian, or authorized representative)

_____ _____

(Date) (Relationship of above person to patient)