**Omaha OB/GYN Associates, P.C.**
119 North 51st St, Suite 200
Omaha NE 68132
Phone: 402-932-8020
Fax: 402-905-3041

# Omaha OB/GYN Associates Authorization for Use or Disclosure of Health Information

*Please provide all information or this Authorization is not valid. Please print or type.*

Patient Name: _____ Date of Birth: _____
Address: _____ Soc. Sec. No.: _____
_____
Telephone No.: _____

I hereby authorize _____
*(Facility/Provider Name and Location)*

To release health information from the medical record of _____
*(Patient name)*

To: _____
*(Recipient Name/Address)*

Fax No.: _____ Telephone No.: _____

For treatment dates: _____
*(Specify dates)*

**Information to be disclosed:**

- ❑ Records from last ___year(s), including progress notes, lab and ultrasounds.
- ❑ Complete medical record including progress notes, lab and ultrasounds.
- ❑ OB Records/US reports
- ❑ Lab Reports date(s) _____
- ❑ US Reports dates(s) _____
- ❑ Progress Note date(s) _____
- ❑ Other _____

**For the following purpose:**

__ Legal
__ Insurance
__ Patient request
__ Other (please explain)

*SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW*

**I specifically authorize the release of information relating to:**

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ HIV/AIDS related information (including test results)
- ❑ Mental Health

I understand and acknowledge that:

- This authorization will be valid for 180 days from the date it is signed.
- My refusal to sign this authorization will not affect my ability to obtain treatment at Omaha OB/GYN Associates, P.C.
- Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
- I understand that I may revoke this authorization at any time by giving written notice to Omaha OB/GYN Associates, P.C. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

_____
***Signature of Patient or Patient's Personal Representative*** ***Date***
*(Parent/Legal guardian must sign if patient is a minor: NE under age 19; IA under age 18)*

_____
*Relationship to Patient, if not the Patient*

*A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.*

**OFFICE USE ONLY**
Copied by:_____ Date:_____
__ To be sent
__ To be picked up Date: _____
__ Picked up on Date: _____
Release by: _____
Released to: _____