



Norfolk Medical Group at Fountain Point

3901 West Norfolk Avenue, Norfolk, NE 68701



Phone: 402-844-8000 FAX: 402-844-8045

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

Patient Name : _____ Date of Birth: _____

Address: _____

Telephone Number: (____) _____ Previous Name (if applicable) _____

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

To release information on the above patient to _____ **NORFOLK MEDICAL GROUP** _____

The following information:

- Records from last ____ year(s), including progress notes,
- lab and x-rays.
- Complete medical record including progress notes, lab and x-rays.
- Lab reports date(s) _____
- X-ray Reports date(s) _____
- Progress Note date(s) _____
- Other _____

For the following purpose: (Please Circle)

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

Please state if you have an appointment:

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

I hereby specifically authorize the release of data and information relating to: (check any that apply)

- HIV / AIDS related testing and sexually transmitted diseases**
- Mental Health**
- Chemical Dependency (Drug / Alcohol)**

This authorization will be valid for 180 days from the date it is signed or until _____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Norfolk Medical Group cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

Signature of Patient or Legal Guardian
(Parent/Legal guardian must sign if patient is a minor: Nebraska under 19)

Relationship to Patient, if not the Patient

Date: _____

OFFICE USE ONLY

Copied by: _____ Date: _____

- To be sent
 - To be picked up Date: _____
 - Sent on Date: _____
 - Picked up on Date: _____
- Released by: _____

Released to: _____