2444 West Faidley PO Box 550 Grand Island, NE 68802-0550
Phone: 308-382-1100
Lab Fax: 308-385-0780 Insurance, M.R. Fax 308-385-0796
OB Fax: 308-385-0781 Peds Fax: 308-385-0789 Family Practice Fax: 308-385-0782

PLEASE DO NOT FAX OVER 20 PAGES

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name______________________________ Date of Birth_______________________

SSN____________________________ Previous Name________________________________

I request and authorize verbal or written release of health care information on the patient named above

TO:	FROM:
Name: Grand Island Clinic	Name: ___________________________
Address: 2444 W Faidley Ave	Address: _________________________
City,State,Zip: Grand Island, NE 68803	City,State,Zip: ____________________

This request and authorization applies to:

___ Entire medical record

___ Health care information relating to the following treatment, condition, or dates of treatment

____

___ Other____

Purpose for Disclosure:

___ Medical Care ___ Personal Information (Charge $20.00 Handling fee +$.50 per page)

___ Insurance ___ Workers' Comp Carrier ___Other_______________________________

I understand and acknowledge that my medical records may contain information related to testing, diagnosis and/or treatment of Alcohol use, Drug use, HIV, sexually transmitted disease, psychiatric disorders and/or mental health information.

____ If I have been tested, diagnosed, or treated for alcohol and/or drug use, HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, and/or mental health issues, I give specific authorization to release all health information contained in the records designated above to such diagnosis, testing, or treatment.

This information has been disclosed to the above named party for records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits further disclosure of this information without specific written consent of the person whom it pertains. A general authorization for the release of medical records or other information is **NOT** sufficient for this purpose.

______________________________ __________
Signature of Patient Date Signed

______________________________ __________
Signature of Patient's authorized representative Date Signed

____
Relationship or status if signed by anyone other than the patient
(Parent, legal guardian, personal representative, etc.)

For office use only
Send Out ________
Pick Up _________
Date Need By _______
Physician/PA Approval _______
Verified Signature With ID_______

This authorization for release of information **EXPIRES 1 YEAR** from the date of the signature, unless written notice for revocation is received by the Grand Island Clinic, Inc. prior to the release of information.

PEDIATRICS	FAMILY PRACTICE	OBSTETRICS & GYNECOLOGY	INTERNAL MEDICINE
Douglas A. Boon, M.D.	Douglas Herbek, M.D.	John P. Reilly, M.D.	W.J. Landis, M.D.
Karen Higgins, M.D.	Adam B. Brosz, M.D.	Matthew J. Brennan, M.D.	
Janice M. Kutilek, M.D.	Susan M. Newman, M.D.	Molly A. Johnson, M.D.	
Timothy A. Gardner, M.D.	Lindsey C. Mettenbrink, D.O.	Kathryn M. Kenna, M.D.	
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Joseph D. Law, M.D.	Jessica Stanton, PA-C	Libby D.J. Crockett, M.D.	
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