Grand Island CLINIC

2444 West Faidley, PO Box 550, Grand Island, NE 68802-0550
Phone: 308-382-1100
Lab Fax: 308-385-0780 Insurance 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

Requested MD: _____

Patient Contact #: _____

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:

Name: _____

Address: _____

City, State, Zip: _____

FROM:

Name: _____

Address: _____

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

For Office Use Only

Date Needed By _____

Provider Approval _____

Verified Signature w/ID _____

_____

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

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
Douglas A. Boon, MD
Karen Higgins, MD
Janice M. Kutilek, MD
Timothy A. Gardner, MD
Melissa K. Law, MD
Joseph D. Law, MD
Sarah Johnson, APRN, NP-C

FAMILY PRACTICE
Douglas Herbek, MD
Adam B. Brosz, MD
Susan M. Newman, MD
Lindsey C. Mettenbrink, DO
Karen Johnson, APRN, NP-C
Jessica Stanton, PA-C
Paul Cramer, APRN, NP-C

OBSTETRICS & GYNECOLOGY
Matthew J. Brennan. MD
Molly A. Johnson, MD
Kathryn M. Kenna, MD
Erica L. Haake, MD
Libby D.J. Crockett, MD

INTERNAL MEDICINE
William J. Landis, MD