INNOVATIVE COMMUNITY HEALTH INSTITUTE, LLC
Saline Medical Specialties - 830 E 1st St. Suite 200 Crete, NE 68333
Lancaster Family Medicine - 4911 N 26th St. Suite 106 Lincoln, NE 68521

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____
Address: _____ City: _____State: _____Zip Code: _____
Phone Number: _____
PCP(Check): ☐ Dr. Gutierrez, MD ☐ Jessica Hernandez-Leon, FNP ☐ Bryan Tran MPAS, PA-C

Provider (who is releasing the information)

Name: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: _____ Medical Record Fax Number: _____

Information to be Released

☐ Complete Medical Records
☐ Immunization Records
☐ Medical Records from (Date)_____ to (Date)_____
☐ Specific Medical Records _____
☐ Billing Record(s) Please List _____

State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

☐ Alcohol, Drug, or Substance Abuse Records (Date) _____ to (Date)_____
☐ Mental Health Records (Date) _____ to (Date)_____
☐ HIV/AIDS Test Results
☐ Sexually Transmitted Diseases

Purpose:

☐Transferring Medical Care ☐ Workman's Compensation Claim
☐Second Opinion or Specialty Care ☐ Insurance Claim
☐ Litigation ☐ Other: _____

Information Sent To:

Name: Lancaster Family Medicine_____
Address: _4911 N 26th St. STE 106_____ City: Lincoln_ State: NE_ Zip Code: 68521___
Phone Number: 402-826-3222_____ Medical Record Fax Number: 402-826-3228_____

By completing this authorization form, I agree that I have the right to revoke this authorization at any time. I understand that the treatment, payment, enrollment, or eligibility for benefits may not be condition on whether I sign this authorization. I understand that the information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law. The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in my providers Notice of Privacy Practice. A fax or photocopy of this authorization shall be considered valid as the original. This authorization is effective for one year from the date on which it was signed.

Signature: _____ Date: _____
Relationship: _____