



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: Saline Medical Specialties

Address: 830 E 1st St. STE 200 City: Crete State: NE Zip Code: 68333

Phone Number: 402-826-3222 Medical Record Fax Number: 402-826-3228

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: Saline Medical Specialties

Address: 830 East 1st St. STE 200 City: Crete State: NE Zip Code: 68333

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: _____