Community Medical Center
Family Medicine Clinic
Falls City, NE 68355

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF INFORMATION

I hereby authorize _____
(Releasor)

whose address is _____
(Address) (City) (State) (Zip)

to release information from the records of:

_____ _____
(Patient Name) (Date of Birth)

TO:

_____
(Recipient of Information)

_____
(Address) (City) (State) (Zip)

SECTION I: The specific type of information to be released includes the following:

_____

_____

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

I understand that the information to be released may include material that is protected by Federal/State Law covering substance abuse, mental health, and/or AIDS-related information.

I SPECIFICALLY DIRECT that the information released include the following:
(Write "Yes" or "No" in **EACH** blank below).

No	Mental Health Information
No	Substance Abuse (Drug/Alcohol) Information
No	HIV screening Test Results
No	AIDS-related Information/Results
No	Suspected Sexual Assault Information

NOTE: MEDICAL RECORDS/REPORTS CONTAINING THIS TYPE OF INFORMATION WILL NOT BE RELEASED IN TOTAL OR IN PART WITHOUT THIS SPECIFIC AUTHORIZATION

I understand that I may revoke this authorization at any time by providing written notice to the above named Releasor. I will not hold this organization or individual liable for divulging such information until such written notice is received by them or until this consent automatically expires (six months from the date of my signature). I hereby acknowledge that I have received a copy of this document.

_____ _____
(Date) (Patient Signature)

_____
(Signature & Title of Parent, Guardian, or Legal Representative)

AUTHORIZATION DUPLICATE PROVIDED BY _____ DATE_____

OD: 6/21/02
RD: 8/30/02

Clear Form