AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

I hereby authorize Children's Physicians to disclose the following information contained in the designated record set (health record).

Patient Name _____ **DOB:** _____
Please Print

Current Address: _____
Street/P.O. Box *City* *State* *Zip*

Home Phone # (_____)_____ **Work Phone # (_____)** _____-_____**(ext._____)**

Covering the period(s) of health care: From (date)_____ **To (date)** _____

Please specify any information you do **NOT** want us to release**:**

_____

_____

Authorize Information Released From:

_____
_____
_____
_____

Please Send My Records To:

_____
_____
_____
_____

This information is to be disclosed for the purpose of _____

_____

Purpose of Release: (check all that apply)
If you are changing physicians, please mark the reason for the transfer (check all that apply):

_____ Age
_____ Moving: ☐ Out of State ☐ Out of Omaha/Area ☐ Location within Omaha Area
_____ To a Children's Physicians office _____ (please indicate Children's Physicians office)
_____ To physicians office, other than Children's Physicians: _____ (please list office)
_____ Dissatisfied: ☐ Health care ☐ Nurse ☐ Physician ☐ Other staff ☐ Appointment Availability
_____ Insurance
_____ Other_____ (Please list)

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition (if not specified, expires 6 months from date of signature).

Children's Physicians and its employees, officers and physicians are hereby released from any and all legal responsibility or liability as to any disclosure of any documents generated by any health care provider other than Children's Physicians. Children's Physicians does not attest to, warrant nor guarantee the accuracy of completeness of documents from other health care providers.
I may be charged a handling fee of $20 and a per-page copying fee of $.50.

_____ _____ _____
Patient/Guardian/or Legal Representative **Relationship to Patient** **Date**

*** A copy of this form is as valid as the original.**