University of Nebraska Omaha

Health Services
102 HPER
6001 Dodge Street
Omaha NE 68182
402-554-2374

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Name: _____ Date of Birth: _____ NU ID # _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone number: (____) _____ ☐ Cell ☐ Home

Complete this section to have your medical records sent to other clinic or given to yourself.

☐ **I authorize the University of Nebraska-Omaha Health Services to release my medical information:**

☐ **To other facility or person as indicated below** ☐ **To Myself as identified above**

Name_____ Phone #: _____ Fax #_____

Address: _____ City_____ State_____ Zip_____

Complete this section to have another office send UNO your medical records.

☐ **I authorize:**

Provider/Facility Name_____ Phone #: _____ Fax #_____

Address: _____ City_____ State_____ Zip_____

To release my medical information indicated below to

University of Nebraska at Omaha Phone 402-554-2374
Health Services 102 HPER Fax 402-554-2387
6001 Dodge Street
Omaha NE 68182

Information to be released and/or obtained:

Date(s) of service: From: _____ to _____

- ☐ History & Physical exam
- ☐ Progress/Interim notes
- ☐ Lab test results
- ☐ X-ray/Imaging (CT, MRI, Ultrasound, Etc.)
- ☐ Immunization Records
- ☐ Other: Please specify: _____

Include Information related to

- ☐ HIV testing/Infection or AIDS
- ☐ Psychiatric/mental health care
- ☐ Alcohol &/or substance use treatment

For the Purpose of:

- ☐ Medical Care
- ☐ Insurance
- ☐ Self
- ☐ Legal/Attorney

Method of disclosure:

☐ Fax ☐ Mail ☐ Verbal

☐ Will pick up on _____ Time:

I understand this authorization may be revoked in writing at any time, except to the extent that action had been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 180 days after the date of execution by the patient or their representative. I may request a copy of this authorization. If I do not sign this form, UNO Health Services and/or UNO Counseling and Psychological Services will not release my information to any person or organization except those authorized by the law. Once disclosed, federal privacy regulations will no longer apply and the information may be subject to re-disclosure. A photocopy of this authorization is as valid as the original.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Nebraska state law allows 30 days for providers to furnish a copy of the medical record after a written request is reviewed.

Office Use Only:

Records, as indicated above: ☐ Faxed ☐ Mailed ☐ Given to Pt ☐ Copied, placed in envelope and put at front desk for pt to pick up. Completed by: _____ Date: _____ Time: _____