2509 Halligan Dr. Suite E
North Platte, NE 69101
308.532.4165

MEDICAL RECORDS RELEASE

Please forward this completed form to ALL physicians who have treated you for this, or a related condition.

TO: Physician name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

I hereby authorize you to release to:

GREATER NEBRASKA DERMATOLOGY CLINIC PC
2509 Halligan Drive, Suite E North Platte, NE 69101
Telephone: (308) 532-4165 Fax: (308) 532-4605

The following Health Information related to my care or treatment including (Check all that apply):

- ☐ Lab reports
- ☐ Consultation reports
- ☐ Entire medical record
- ☐ Pathology reports
- ☐ Doctor's office notes
- ☐ Financial records
- ☐ Other_____
- ☐ Information from my Medical Record during the period _____ to _____

I understand that my Provider may not condition my right to receive health care or benefits on my signing this authorization. When my information is used or disclosed to other parties as instructed in this authorization, I understand that my Provider will not have the ability to monitor whether my health information may be further used or disclosed by such parties, and that my health information may no longer be protected by federal and state privacy laws.

For the purpose of release of medical records information, a photocopy or facsimile copy of my signature may be considered as acceptable, legal and binding as my original signature. This release is valid for a period of six months from the date of my signature unless I indicate an earlier date here: _____

I understand that I have the right to revoke this authorization at any time by providing my Provider with written notice, sent by certified mail or hand delivery to the attention of the Privacy Officer at the address noted above. By signing below, I acknowledge receipt of a singed copy of this authorization.

By: _____ Date: _____
(Signature of patient, guardian or authorized representative)

_____ _____
Patient Name Date of Birth

_____ _____
Address Social Security Number

_____
City, State, Zip