I hereby authorize and request release of my medical records:

FROM: _____________________________             TO:    ____________________________
_____________________________                        ____________________________
_____________________________                        ____________________________

Information to be disclosed:
From (date)__________________________to (date)_____________________________

☐ Discharge Summary ☐ EKG/EEG Reports ☐ X-ray Images
☐ History and Physical Exam ☐ Emergency Room Record ☐ Prenatal (Pregnancy) Records
☐ Operative Report ☐ Clinic Notes ☐ Physical/Occupational Therapy Notes
☐ Pathology Report ☐ Psychiatric Information ☐ Substance Use Disorder Notes
☐ Other (please specify) ☐ Laboratory Results

Release Format (choose one): ☐ Mail ☐ Pick Up ☐ One Chart Patient Portal ☐ Email ______________________

Purpose of Release: ☐ Continuation of Care ☐ Attorney ☐ Personal records ☐ Other ______________________

This statement of consent can be revoked at anytime before disclosure of the information, and expires on _______________ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

PROHIBITION ON REDISCLOSURE OF ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: This information has been disclosed from records protected by federal law. 42 CFR. Part 2 prohibits any further disclosures of these records without specific written authorization of the person to whom it pertains, or as otherwise permitted by law.

I understand Nebraska Medicine and its affiliates will not condition evaluation or treatment on whether I sign this authorization.

Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.