Dr. Robert Plambeck, MD, FACOG

1001 South 70th Street, Suite 220 Lincoln, NE 68510
Phone: 402-486-1379   Fax: 402-486-1459

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read carefully before signing and dating. **All sections must be complete to be HIPAA compliant.**

Patient Name: ____ **Birthdate:** ___________________
PLEASE PRINT MM/DD/YYYY

Have you ever used another name (maiden, adopted, nickname, etc) [ ] Yes __________________________ [ ] No

Address: ____ **Phone:** ______________________

STREET ADDRESS CITY STATE ZIP

INFORMATION TO BE RELEASED *FROM*:
INDICATE SPECIFIC CLINIC/PROVIDER

____
CLINIC OR PROVIDER

____
STREET ADDRESS

____
CITY, STATE, ZIP

____
PHONE FAX

INFORMATION TO BE RELEASED *TO*:

____
CLINIC OR PROVIDER

____
STREET ADDRESS

____
CITY, STATE, ZIP

____
PHONE FAX

INFORMATION AUTHORIZED TO RELEASE:

[ ] **All** medical records/dates [ ] OB records [ ] Mammogram [ ] Labs [ ] Ultrasound [ ] Pap

[ ] Medical records for the following dates: _______________ to _______________

[ ] Other (please specify information needed____

PURPOSE: [ ] Personal [ ] Transfer of care [ ] Continuity of care [ ] Other: ______________________________

REVOCATION & AUTHORIZATION:

I understand that I have the right to revoke my authorization at any time by notifying the above-named provider of information, in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute as a breach of my rights to confidentiality. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

I understand that the information released from my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or gene related impairments, including genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. Dr. Robert Plambeck is hereby authorized to release all information related to such diagnosis, testing, and treatment, unless specifically excluded below.

EXCLUSIONS: [ ] Drug/alcohol abuse treatment & diagnosis [ ] HIV/AIDS/STD diagnosis, treatment, & testing
[ ] Behavioral & mental health records

PRINT PATIENT NAME: ____ **DATE:** ________________________________

LEGAL SIGNATURE: ____ **RELATION TO PATIENT:** ______________________________

(Parent/guardian signature if patient is under age of 19) (is signee is other than self)

PLEASE NOTE: This authorization will remain in effect for six months after the date that appears above.