# Dr. Robert Plambeck, MD, FACOG

5610 Hickory Crest Road Lincoln, NE 68516
Phone: 531-333-6251

## 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
Dr. Robert Plambeck
CLINIC OR PROVIDER
5610 Hickory Crest Road
STREET ADDRESS
Lincoln, NE 68516
CITY, STATE, ZIP office@drplambeckobgyn.com
531-333-6251
PHONE EMAIL

**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.