AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ DOB:_____

Patient Address: _____Phone#:_____

I hereby authorize Nebraska Hematology-Oncology, PC and its employees to:

-) **Request information from: _____**
  (Name, phone, FAX)
-) **Request information from: _____**
  (Name, phone, FAX)
- o Release information to: _____
  (Name, phone, **FAX**)
- o Release information to: _____
  (Name, phone, **FAX**)

Including, if applicable, the following health information related to testing, diagnosis and/or treatment for (please initial applicable line):

_____ Complete Medical Records
_____ HIV-Related Information
_____ Genetic Testing
_____ Progress Notes
_____ Correspondences
_____ Alcohol/Drug Treatment Information
_____ Mental Health Information
_____ Lab/Pathology Results
_____ Hospital Records
_____ Other

Conditions: We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures: When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration: This authorization shall expire upon the earliest of (_____) or one hundred eighty (180) days from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation: You have the right to revoke this authorization at any time in accordance with our Notice of Privacy Practices. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

By signing below, you acknowledge receipt of a signed copy of this authorization.

_____ _____

Signature Date

**Note: If signed by someone other than the patient, we need written proof of your authority. If form is not filled out in its entirety, your request may not be completed.

Please email completed form to **medrecords@yourcancercare.com** or FAX to **402-817-0189**