Norfolk Medical Group at Fountain Point
3901 West Norfolk Avenue, Norfolk, NE 68701 Phone: 402-844-8000 FAX: 402-844-8045

Please provide all information requested or this Authorization is not valid. **Please print or type.**

Patient Name :_____Date of Birth: _____

Address:_____

Telephone Number: (_____)_____Previous Name (if applicable)_____

I hereby authorize _____**Norfolk Medical Group** _____
(Facility/Provider Name and Location)

To release information on the above patient to _____

The following information:

- ☐ Records from last _____year(s), including progress notes,
- ☐ lab and x-rays.
- ☐ Complete medical record including progress notes, lab and x-rays.
- ☐ Lab reports date(s) _____
- ☐ X-ray Reports date(s) _____ _____
- ☐ Progress Note date(s) _____ _____
- ☐ Other _____ _____

For the following purpose: (Please Circle)

- ☐ Legal
- ☐ Insurance
- ☐ Patient request
- ☐ Other (please explain)

Please state if you have an appointment:

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I hereby specifically authorize the release of data and information relating to: (check any that apply)

- ☐ ☐ **HIV / AIDS related testing and sexually transmitted diseases**
- ☐ ☐ **Mental Health**
- ☐ ☐ **Chemical Dependency (Drug / Alcohol)**

This authorization will be valid for 180 days from the date it is signed or until_____, whichever is shorter. This authorization may be revoked 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 a breach of my rights to confidentiality. Norfolk Medical Group cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

_____
Signature of Patient or Legal Guardian
(Parent/Legal guardian must sign if patient is a minor: Nebraska under 19)

_____
Relationship to Patient, if not the Patient

Date:_____

OFFICE USE ONLY
Copied by:_____Date:_____

- ☐ To be sent
- ☐ To be picked up Date; _____
- ☐ Sent on Date:_____
- ☐ Picked up on Date:_____

Released by:_____

Released to:_____