



MIDWEST HEALTH PARTNERS, P.C.

P.O. BOX 209
1410 N. 13TH STREET
NORFOLK, NE 68702
PHONE: 402-379-2322 FAX: 402-379-0888

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Make sure all information is complete to prevent a delay in release of information. **Please print.**

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Previous Name (if applicable): _____

This will authorize **(Provider)**

To release to **(Provider)**

Initial	The following information:	From	Dates	To:
_____	Complete medical records	_____	_____	_____
_____	Lab reports	_____	_____	_____
_____	X-ray reports/films	_____	_____	_____
_____	Progress notes	_____	_____	_____
_____	Path, Lab, EKG reports	_____	_____	_____
_____	X-ray, EMG reports	_____	_____	_____
_____	Other	_____	_____	_____

For the following purpose:
 ___ To update Primary M.D.
 ___ Referral to another M.D.
 ___ Want/need 2nd opinion
 ___ Changing doctors/
 providers due to the
 following:
 ___ Insurance change
 ___ Dissatisfaction with care
 ___ I am moving
 ___ Other _____

Specific Authorization For Release of Information Protected By State/Federal Law.

I specifically authorize the release of data and information relating to: **(patient to initial any & all that apply)**

___ HIV/AIDS related test or information. ___ Mental Health Information. ___ Drug/Alcohol Information. ___ Sexually Transmitted Disease Information

This authorization will be valid for 90 days from the date of signature, unless specific date stated. This consent may be revoked at any time by notifying the above named provider of information. This release does not include hospital records or records we received from other physicians. This authorization is being given with the understanding that the receiver may not further disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is permitted by appropriate state/federal law.

Records may be mailed or faxed.

Office Use:

Signature of Patient or Legal Guardian

Copied by _____ Date _____
Mailed/faxed on (Date) _____
Picked up on (Date) _____ By _____
Initials _____

Relationship, if not the parent

Date _____