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**:	Dates From	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.

_____
Signature of Patient or Legal Guardian

_____
Relationship, if not the parent

Date_____

Office Use:
Copied by_____Date_____
Mailed/faxed on (Date)_____
Picked up on (Date)_____By_____
Initials_____