



MIDWEST HEALTH PARTNERS, P.C.
FAMILY MEDICINE & CONVENIENT CLINIC
 1410 N. 13th ST. P.O. BOX 209 NORFOLK, NE 68702
 PHONE: 402-371-0123 FAX: 402-371-5360

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			For the following purpose:
		From	To		
_____	Complete medical records	_____	_____	_____	To update primary M.D.
_____	Lab reports	_____	_____	_____	Referral to another M.D.
_____	X-ray reports/films	_____	_____	_____	Want/need 2 nd opinion
_____	Progress notes	_____	_____	_____	Changing doctor/provider
_____	Path, Lab, EKG reports	_____	_____	_____	due to the following:
_____	X-ray, EMG reports	_____	_____	_____	Insurance change
_____	Other	_____	_____	_____	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/Parent or Legal Guardian Relationship, if not the Parent Date: _____

OFFICE USE:

Copied By: _____ Date: _____ Date Picked Up: _____ By: _____
 Faxed: _____ Mailed: _____ Date: _____ Initials: _____