

Patient Authorization for Use and Disclosure of Protected Health Information

This authorization is valid for patient initiated requests to use or disclose their PHI to a third party when the reason is not related to treatment, payment or healthcare operations.

**Nebraska Pulmonary Specialties, LLC
1500 S. 48th St. Suite 800
Lincoln, NE 68506**

PATIENT'S FULL NAME (include birth name if different) Date of Birth _____

By signing this authorization Nebraska Pulmonary Specialties, LLC to use and/or disclose certain protected health information (PHI) about me to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This authorization covers the following individually identifiable health information about me:

- A summary of my medical history and an overview of my visits, including my diagnoses, between and including the date (s) _____ to _____
or; all dates.

- Office notes describing my treatment for _____
or; any condition between and including the date(s) _____ to _____
or; all dates.

- Medical testing reports and correspondence regarding _____
between and including the date(s) _____ to _____
or; all dates.

- Other (specifically describe, such as date (s) of services, type of services, level of detail to be released, origin of information, etc.): _____

Reason for use or disclosure: _____

This authorization will expire on _____ (expiration date or defined event)

I understand that if this authorization is used to transfer copies of my records to a new physician at my request, only a summary of my medical history and an overview of my visits as described above will be sent. If more detailed information is deemed necessary for proper continuation of treatment by the physician sending or receiving this information, it will be sent without any further authorization from me, unless I have objected to this in writing. When my information is used or disclosed under this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Nebraska Pulmonary Specialties, LLC has acted in reliance upon this authorization. My written revocation or objection must be submitted to the Privacy Office at: 1500 S. 48th St. Suite 800, Lincoln, NE 68506.

Signed by: _____
Signature of patient or legal guardian Relationship to patient _____

_____ Date _____
Print name of patient or legal guardian

For office use only:
 signature/authority verified Copied and sent by _____ Date: _____