

Norfolk Family Medicine
900 West Norfolk Avenue, Suite 100
Norfolk, NE 68701
(402) 371-2326

**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL MEDICAL RECORDS AND/OR INFORMATION**

Patient Name: _____ Date of Birth: _____ Previous Name: _____
(Full Legal Name)
Address: _____ City: _____ State: _____

I, the above named patient or guardian of the above named patient, authorize Dr. Timothy Davy, Dr. Edward Wicker, or Amy Majchrowitz, APRN, FNP-BC to:

- release records to _____
- receive records from _____
Name of Healthcare Facility, Physician, etc.

Street Address

City/State/Zip Code

Specify information to be released: Dates from: _____ To: _____

Please initial all that apply: ***See back**

- | | |
|---|--|
| _____ Complete Records | _____ Other _____ |
| _____ History & Physical Examinations | _____ AIDS/HIV Tests and/or information
(Acquired Immune Deficiency Syndrome) |
| _____ Progress Notes | _____ Drug & Alcohol usage and treatment |
| _____ X-rays, Laboratory, & EKG Reports | _____ Mental Health |
| _____ Pathology Reports | _____ Dr. _____'s Records only |

The purpose of this disclosure of information is: _____

I fully understand that if I refuse to sign this authorization, my medical record information will not be released. This release does **NOT** include hospital records or records from another physician that were sent to this clinic, however, for insurance purposes, hospital records might be included.

I understand that this consent is revocable at any time prior to the release of this information. This authorization will expire six months from the date of signature below.

(Signature of patient) Date: _____

(If signed by other than patient, state relationship) Date: _____

(Signature of witness) Date: _____

Approved By: _____ **Records Sent:** _____ **Picked Up:** _____

Explanation of release of information:

1. At Norfolk Family Medicine, we will release to referred physicians to provide continuity of care for a patient. The patient will sign a “blanket” release of information at time of intake for referred releases.
2. However, patients will be asked, as much as possible, to sign a specific release of information at time of office visit for release to a referred physician.
3. NFM will not release records received from other offices, including physician letters from other clinics, to a referred physician.
4. NFM will avoid verbal release of information. Exception to this is when there is a phone interaction between a medical care provider (doctor or nurse) regarding a health concern and a referral to another physician is then initiated. In this case, the nurse or provider has talked directly with the patient or guardian of the patient, and knows patient identity. No verbal requests for release of information will be honored when initiated by the patient via phone.

*Inclusive in the records may be information regarding alcohol and drug usage, or reference to HIV or STD testing and results. This information may be a part of the history and/or secondary to the primary object of visit, but necessary for treatment. It cannot be extracted from office visit documentation when sending records.