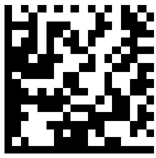
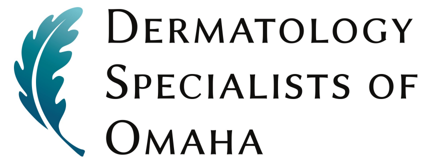

Consent Forms

Place Patient Label Here



Release of Medical Records

Patient Name: _________________________________ Date of Birth: ___________________________

Authorization: The undersigned hereby authorizes Dermatology Specialists of Omaha LLC to:

( ) Release records to: ( ) Receive records from:

____

____

____

Please release the following health information:

( ) Complete medical record or,

( ) Medical records from dates_____________ to _____________ or,

( ) Specific medical records as listed: ____

Including, if applicable, the following health information related to testing, diagnosis, and/or treatment for (please initial applicable line): _________ HIV (AIDS virus), _________ sexually transmitted diseases, _________ mental health, or _________ drug and/or alcohol abuse.

For the following purpose(s): (may state "per my request")____

Conditions: We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further Uses and Disclosures: When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

Expiration: This authorization shall expire upon the earlier of ________________ or one year from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

Revocation: You have the right to revoke this authorization at any time by providing us with written notice by certified mail, fax or hand delivery to the following address:

Dermatology Specialists of Omaha
Attn: Privacy Officer
909 N. 96th St., Suite 201
Omaha, NE 68114
Fx (402)330-4626

When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

By signing below, you acknowledge receipt of a signed copy of this authorization.

____	____
Printed Name	**Relationship (Self, Father, Mother, Power of Attorney, etc.)**
____	____
Signature	**Date**

Please Note: This form must be filled out in its entirety. If signed by someone other than the patient, we need written proof of your authority.