2001 Pine Lake Road
Suite 300
Lincoln, NE 68512
Phone: 402-447-7221
Fax: 402-447-7222

Kelli Bremer, MD, PC
Buda Psychiatry, PC

Authorization for Disclosure of Health Information

_____ _____
Name (Last, first, middle initial) Date of Birth

_____ _____ _____ _____
Street address City State ZIP Code

I understand that the specified information to be released may include but is not limited to history, diagnosis and or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS.

_____I hereby authorize **South Lincoln Psychiatry, LLC** to release protected health information to:

_____I hereby authorize the below named organization **to release information to South Lincoln Psychiatry, LLC**:

Name of Organization/Individual: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone Number: _____ Fax Number: _____

INFORMATION TO BE RECEIVED:

___ Medical History, Examination, Reports ___ Social History ___ Academic Records ___ Entire Record
___ Psychological/Psychiatric Evaluation ___ Consultations ___ Prescriptions ___ Open communication
___ Hospital Records and Reports ___ Terminations Summary ___ Laboratory Reports ___ Treatment Plan
___ Other (Specify):_____

SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF: (Check applicable categories)

___ Evaluation and/or Treatment ___ Further Medical Care ___ Legal Investigation or Action ___At the request of the pt.
___ Follow up ___ Insurance Eligibility/Benefits ___ Changing Physicians
___ Educational Planning and Programming ___ Personal ___ Coordination of Care
___ Other (Specify)_____

I understand that if the person (s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect or Copy the Health Information to Be Used or Disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting South Lincoln Psychiatry, LLC. **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization**- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: South Lincoln Psychiatry, LLC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing South Lincoln Psychiatry, LLC from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (fax) copy shall have the same effect and authority as the original copy.

Signature of Patient or Legal Representative:_____Date: _____

(If signed by other than patient, state relationship & authority to do so)

Witness_____ Date:_____