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Lincoln, NE 68512  
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Nancy Gerrard, APRN

**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 **Nancy Gerrard, APRN** to release protected health information to:

\_\_\_\_\_ I hereby authorize the below named organization to release information to **Nancy Gerrard, APRN**:

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 Nancy Gerrard, APRN. **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: Nancy Gerrard, APRN. 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 Nancy Gerrard, APRN 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:** \_\_\_\_\_