NEBRASKA CANCER SPECIALISTS

the Physicians of Oncology Hematology West

www.nebraskacancer.com

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name:	Date of Birth:
Address:	Phone: ( )
City/State/Zip:	

I authorize the release of medical information as indicated below:

To:	**From:**
Physician:	**Physician:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**
Direct Address:	**Direct Address:**

☐ Office progress notes
☐ Chemotherapy Flow sheets
☐ X-Ray
☐ Lab
☐ Pathology/Operative Notes
☐ Consultations
☐ Entire Medical Record
☐ Other_____

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 ____drug and/or alcohol abuse

Covering the period(s) of care: from_____to_____

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 & 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 priced 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 medical records department of custodian with whom the original authorization was submitted. When we received 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 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:	DOB:	Date:
Signature: ☐ By checking this box, I validate the typed name above as an electronic representation of my signature.		Relationship:

NOTE: If signed by someone other than the patient, we need written proof of your authority.

Alegent Health Cancer Center - Bergan
7500 Mercy Rd.
Suite 1300
Omaha, NE 68124
402.393.3110
402.393.4499 *fax*

Methodist Estabrook Cancer Center
8303 Dodge St.
Suite 250
Omaha, NE 68114
402.354.8124
402.354.8127 *fax*

Midwest Cancer Center - Papillion
611 Fenwick Dr.
Papillion, NE 68046
402.593.3141
402.593.3145 *fax*

Midwest Cancer Center - Legacy
17201 Wright St.
Suite 200
Omaha, NE 68130
402.334.4773
402.330.7463 *fax*

Health Park Plaza - FAMC
450 E. 23rd St.
First Floor
Fremont, NE 68025
402.941.7030
402.941.7032 *fax*