NEBRASKA CANCER SPECIALISTS

Phone: 402.691.6964
Fax: 402.334.7846
Email: medrecords@NebraskaCancer.com
Mail to: Nebraska Cancer Specialists
17445 Arbor Street Suite 310 | Omaha, NE 68130

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name _____ DOB: _____ / _____ / _____

Address _____ Patient 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 admin@ncs.oncoemrdirect.com

❏ Office progress notes
❏ Chemotherapy Flow Sheets
❏ X-Ray
❏ Lab
❏ Pathology/Operative Notes
❏ Consultations
❏ Entire Medical Record
❏ Mental Health Records
❏ 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

Cover 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:

Patient Name _____ DOB: _____ / _____ / _____ Date _____

Signature _____ Relationship _____

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