8550 Cuthills Circle, Lincoln NE 68526

☐ Behavioral Health	☐ Neurology	☐ Primary Care
Phone: 402-476-6060	Phone: 402-476-6060	Phone: 402-466-3355
Fax: 402-476-6809	Fax: 402-476-6809	Fax: 402-466-3410

Patient Name: ____ Date of Birth: _____________________________________

I hereby authorize Alivation Health, LLC: "Please Select One"

☐ To "Provide" Protected Health Information "To":
(patient agrees that Alivation can *share* your health information *with* the person below)

☐ To "Receive" Protected Health Information "From":
(patient agrees that Alivation can *receive* your health information *from* the person below)

☐ To "Receive" & "Provide" Protected Health Information "From":
(patient agrees that Alivation can *receive* your health information *from* the person below)

Name:____ Address:____
Phone:____ Fax:_______________________________________
Email:____ @ _______________________________________

Purpose of Request (*Must check one*):

☐ Request to communicate to Patient/Individual * note: that some items will not be released due to specialty
☐ Attorney/Legal ☐ Coordination of Care or Consultation
☐ Transferring Care ☐ Billing/Claims ☐ Other(specify)__________________________

I Request My Records be Provided:
☐ Electronically via MyHealthRecord (Via Patient portal) ☐ Paper (fees may apply) ☐ Electronically via email* ☐ Electronically via CD*

Please check the type of information to be released *(check all that apply)*:
NOTE: *This form MAY NOT BE used to release Psychotherapy Notes*

☐ From (date): ________________________ To (date): ___________________________
**Includes all records through the date the patient or patient representative signs this authorization*

☐ Consultation(s)/ Encounter Notes	☐ PFT/Spirometry	☐ History/Physical Exams
☐ Physician(s) Orders	☐ Diagnostic Testing Reports	☐ Immunization Records
☐ Sleep Study Reports	☐ Lab Test Result(s)	☐ Questionnaires
☐ EKG/Cardiology/Report(s)	☐ Patient Medication(s)	☐ Radiology/Image(s)
☐ Pathology Report(s)	☐ Other (specify): ___________________________	

Release of Information Updated: 4.08.19aw

Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases:
I understand my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases (such as hepatitis, gonorrhea), psychiatric care, drug and alcohol abuse/treatment, or other sensitive information, I agree to its release. *Check One*: ☐ Yes ☐ No

EXPIRATION DATE: I understand that this authorization shall be in force and effect **until ___________________ (state the specific expiration date or the event triggering the expiration)** at which point the authorization will expire. If left blank, release will automatically set to expire one year from the date signed.

REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization at any time by sending written notification to Alivation Health, 8550 Cuthills Circle, Ste 100, Lincoln, NE 68526. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

AUTHORIZATION FOR MARKETING: I understand that the authorized use or disclosure will result in a direct or indirect payment to the providing organization from a third party. (This section is necessary only if the authorization is for marketing purposes and involves direct or indirect payment to the covered entity from a third party.)

CONDITIONING OF AUTHORIZATION: I understand that the providing organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on me providing an authorization for the requested use or disclosure. Unless my treatment is 1) related to the research, 2) my health care services are provided solely for creating protected health information for disclosure to a third party, or 3) if the authorization is sought for a health plan to determine eligibility or enrollment for underwriting purposes.

Signature of Patient or (Legal Guardian): ____ Date: _______________________

Print name if signing as Legal Guardian: ____

Witness Signature (Alivation Health Team Member):

Print Name: ____ Date: ___________________

Verified by (*OFFICE USE ONLY*):

☐ Action Needed: Comment: ____

☐ No Action Needed: Comment: Please keep on file

Task Sent to: ☐ Team Member: ________________
☐ BH Medical Records
☐ PC Medical Records

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