SEND FORM TO:
Think Medical Records Department
7100 West Center Rd, Omaha, NE 68106
T: 531-222-8957 | Fax: 402-506-9093 | medical.records@thinkhealthcare.org

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Type of Information to be Disclosed

Check applicable

○ All medical information in record**
○ Imaging *only* (Dates _________)
○ Lab Results *only* (Dates _________)
○ Immunizations *only*
○ Other, Specify:

____
____

****Important Note****
Your medical record may include ***highly sensitive*** information (e.g. mental health records, psychotherapy notes, records of drug or alcohol abuse, HIV, STDs or other sensitive diagnoses). By selecting below, you agree to release this information as well.
IF THIS SECTION IS LEFT BLANK, THE INFORMATION WILL BE EXCLUDED FROM DISCLOSURE

Include ***highly sensitive* information? ○ YES ○ NO

Patient Information

I request access as the ○ Patient ○ Parent ○ Guardian, Representative, or POA *(documentation required)*

Name of Patient *(print clearly)*	SSN	Date of Birth
Address	City, State, Zip Code	Contact Phone Number

Manner of Information Requested: ***(charges may apply)***

○ Paper copy ○ CD Copy *(for imaging only)* ○ Transfer to New Provider ○ Inspection of Records *(by appointment)*

Recipient or Sender Information

SEND medical information TO *(Check ○ if same as the above)*	RECEIVE medical information FROM *(Only use if sending information* to *Think* ○ *)*
Name of Person or Entity to *Receive*	Name of Person or Entity to *Receive*
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone and Fax, if necessary	Telephone

By signing below I authorize Think to release all medical information in the way that I have indicated on this form. I understand that I may revoke this authorization at any time in writing, subject to Think's Notice of Privacy Practices. I understand that I can refuse to sign this form and still receive treatment. I understand that Think cannot guarantee the recipient will not inappropriately re-disclose this information. I agree that this authorization will expire one (1) year after the date of signing.

Signature of Patient or Representative	**Date**	**Name, Relationship** ***(if not the patient)***

FOR OFFICE USE ONLY

Date received: **Approved by:** **If denied, reason:**