FAMILY MEDICINE ASSOCIATES

Leland F. Lamberty, M.D., A.B.F.P.
Janet Bernard, M.D., A.B.F.P.
David Priebe, M.D., A.B.F.P.
Emily Jones, M.D., A.B.F.P.
Lyndann Sokolowski, A.P.R.N.

RHEUMATOLOGY
Kristin S. Lake, M.D., F.A.C.R.

500 W Leota, Suite 100
North Platte, Nebraska 69101
308-534-4440
308-534-7675 - Fax

This authorization is effective for one year from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Family Medicine Associates. I understand that I have the right to inspect the information to be disclosed upon the proper notification to and under conditions established by Family Medicine Associates.

INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.

PATIENT IDENTIFICATION:

Name _____

Address _____

_____

Date of Birth _____ Soc. Sec. _____

Parents/Previous Name(s) _____

PROVIDER: (Who is releasing the information)

Name _____

Address _____

_____

_____

REQUESTOR: (Where do you want the information sent)

Name _____

Address _____

_____

_____

INFORMATION REQUESTED:

- ☐ Complete Records
- ☐ Immunization Record _____
- ☐ Lab Data, Date _____
- ☐ X-ray Data, Date _____
- ☐ EKG, Date _____
- ☐ X-ray Original Film, Date _____ Needs to be returned in 30 days
- ☐ Progress Note, Date _____
- ☐ History & Physical, Date _____
- ☐ Discharge Summary, Date _____

I specifically authorize the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ HIV/AIDS related information (including test results)

PURPOSE OF RELEASE:

- ☐ Transferring Medical Care
- ☐ Moving
- ☐ Insurance Coverage
- ☐ Other _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT, IF NOT SIGNED BY PATIENT _____