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Lincoln, Nebraska 68506
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Two-Way Authorization to Release Confidential Health Information

In accordance with Federal and State statutory requirements concerning the confidentiality of records, I request and give my permission to release/exchange information regarding the following individual:

Patient Name: _____ Date of Birth: _____

(Please Print)

I hereby authorize the following medical information to be released between:

AND

Integrity Dermatology
1620 South 70th Street, Suite 103
Lincoln, NE 68506

The specific health information to be released/exchanged is:

_____ Pathology Records _____ Complete Medical Record
_____ Laboratory Records _____ Other _____
_____ Most Recent Progress Note _____

Integrity Dermatology wants you to be aware of the potential that this information, once forwarded to the other party, could be re-disclosed and no longer protected.

This requested information is to be used for the purpose of _____.

I understand that this consent may be revoked in writing at any time. In any event, if not previously revoked, this consent will expire on _____ or one year from the signature date. NOTE: A photocopy or fax of this signed release form is as valid as the original.

Signature of Patient: _____ Date: _____

Signature of Personal Representative: _____ Date: _____

Signature of Witness: _____ Date: _____

Notice of Confidentiality

This document contains confidential information which may also be legally privileged and which is intended only for the use of the individual or entity named above. If the reader is not the intended recipient or the employee or agent responsible for delivering it to the intended recipient, you are hereby on notice that you are in possession of confidential and privileged information. Any dissemination, distribution, or copying of this document is strictly prohibited. If you have received this in error, please immediately notify the sender by telephone and return the original document to the sender at the above address via the U.S. Postal Service.