1620 South 70th Street Suite 103
Lincoln, Nebraska 68506
Office (402) 318-3550
Fax (402) 318-3546

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

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