

FALLBROOK FAMILY HEALTH CENTER
755 Fallbrook Blvd., Suite 100 Lincoln, NE 68521 (402) 441-3575

Patient Authorization for record transfer to Fallbrook Family Health Center

Patient Name

Other Names Used

Address

Phone Number

Date of Birth

I authorize (name of old doctor): _____ at
Name of Health-Care Facility

Address of Health-Care Facility

To use and/or disclose the following protected health information about me:

All Medical Records

Records pertaining to (Specify): _____

To: **Fallbrook Family Health Center, **
755 Fallbrook Blvd., Suite 100, Lincoln, NE 68521 (402) 441-3575.

The information will be used/disclosed for the following purpose:

Transfer Care to Fallbrook Family Health Center

Obtain a Second Opinion

Other (Specify): _____

Signature of Patient/Guardian

Print Name of Guardian

Witness

Date

I specifically authorize the release of data and information pertaining to: (check appropriate box)

- | | | | |
|---|----------------|----|-----|
| 1. Substance Abuse (alcohol/drug abuse) | Does Not Apply | No | Yes |
| 2. Mental Health | Does Not Apply | No | Yes |
| 3. Hiv-Related Information (AIDS related testing) | Does Not Apply | No | Yes |

Signature of Patient or Legal Guardian

Expiration Date (specify date or event): _____

*This authorization shall remain in effect for 90 days unless otherwise specified.