AUTHORIZATION FOR RELEASE OF INFORMATION

NAME:	DOB / ID#
ADDRESS: City State Zip code	PHONE: ( ) -

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize the Lincoln-Lancaster County Health Department to:

Release the information described here:	
Release this information to:	
Purpose of the release:	

EXPIRATION DATE	I understand that unless revoked this authorization will expire on this date

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT or AUTHORIZED REPRESENTATIVE
Print name:
RELATIONSHIP TO PATIENT

REVOCATION SECTION:	I hereby revoke this authorization
SIGNATURE	DATE

Rights and Assurances

- I understand that information is disclosed pursuant to this authorization may be **redisclosed** to additional parties and no longer protected.
- I understand that I may **revoke** this authorization at any time by signing the revocation section of my copy of this form and returning it to Lincoln-Lancaster County Health Department, 3140 N Street, Lincoln, NE 68510, Attn: (name of program)
- **Right to Refuse to Sign this Authorization** - I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Inspect** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. The procedure for how I may inspect or copy my health information is explained in the City of Lincoln's Notice of Privacy Practices, a copy of which has been previously provided to me.
- **Right to Receive a Copy of Authorization** - I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form.
- **Right to Receive Treatment** – I understand I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization.