MyBridge
PRIMARY CARE
(402) 771-4071 | Fax: (833) 455-8464 | admin@mybridgepc.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ **DOB** _____

PHONE _____

1. PERSON/ORGANIZATION

☐ RELEASE information to ☐ OBTAIN information from

Name/Organization _____

Address _____

Phone _____ Fax _____

2. INFORMATION REQUESTED

☐ Complete medical record
☐ Primary care records
☐ Hospital records
☐ Emergency room records
☐ Rehabilitation/skilled nursing facility records
☐ Laboratory results
☐ Imaging/radiology reports
☐ Medication list
☐ Immunization records
☐ Specialist records
☐ Other: _____

Date Range: ☐ All records From: _____ To: _____

3. PURPOSE

☐ Continuing medical care
☐ Coordination of care
☐ Insurance
☐ Legal
☐ Personal use
☐ Other: _____

4. DELIVERY

☐ Fax: (833) 455-8464 ☐ Other: _____

5. AUTHORIZATION & SIGNATURE

I authorize the release or obtaining of my health information as indicated above. I understand that:

- I may revoke this authorization in writing at any time, except to the extent information has already been released.
- I may request a copy of this authorization.
- Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- This authorization expires one year from the date signed, unless an earlier expiration date is specified below.

Expiration Date (if different): _____

Patient/Authorized Rep. Signature _____ Date _____

Printed Name _____ Relationship to Patient _____