dermatology associates OF LINCOLN

6969 South St | Lincoln, NE 68506 | 402-413-7460
Casey D Bowen, MD ● Gina L Weir, MD ● Jay Arthur, PA-C ● Christina Meyer, PA-C ● Meredith McManaman, PA-C

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:	Account #:
Patient Address:	Patient City, State Zip:	

THIS WILL AUTHORIZE:

Name of Person or Organization _____

Address, City, State Zip _____

TO RELEASE INFORMATION TO:

Name of Person or Organization _____

Address, City, State Zip _____

Release the following information:

□ All Medical Records □ Lab Reports □ Pathology Reports □ Treatment Plan
□ Allergies □ Medications □ Procedure Notes □ Visit Notes
□ Other _____

Omit the following information:

□ HIV Records □ Substance Abuse Records
□ Mental Health Records □ Other _____

Purpose of Release:

□ Insurance Purposes □ Legal □ Physician Change □ Treatment/Referral
□ Other _____

Method of Delivery:

□ Mail □ Fax ( ) _____-_____ □ I will pick up

Dermatology Associates of Lincoln will not receive payment or other remuneration from a third party in exchange for using or disclosing information. You do not have to sign this authorization in order to receive treatment from Dermatology Associates of Lincoln. When this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time by providing a written request to the Dermatology Associates of Lincoln Privacy Officer, except to the extent that we have already acted in reliance upon this authorization.

I authorize the use and disclosure of the medical records and health information indicated above:

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____ _____

Parent/Guardian Name (Printed) **Relationship to Patient**

Updated 7/14/2022