RUSTAD DERMATOLOGY PC

Authorization for Release of Information

Patient Name_____ Date of Birth _____

Address _____City _____ State ____ Zip Code _____

☐ **Send From (Sender)**

☐ **Send To (Recipient)**

Rustad Dermatology PC

1919 South 40th Street, Suite 330

Lincoln NE 68506

Phone 402-484-6222

Fax 402-484-6253

☐ **Send From (Sender)**

☐ **Send To (Recipient)**

Name _____

Address _____

City _____ State ____ Zip _____

Phone _____

Fax _____

Information requested from (date) _____ **to (date)** _____

- ☐ All records
- ☐ History and physical
- ☐ Hospital discharge summary
- ☐ Laboratory reports
- ☐ Operative notes
- ☐ Pathology reports
- ☐ Progress notes
- ☐ Radiology reports

Other (specify) _____

Purpose of information to be released:

☐ Treatment ☐ Follow-up ☐ Insurance ☐ Legal ☐ Other (specify) _____

I hereby authorize the sender to furnish the information Requested to the Recipient. I hereby also released the Sending and Receiving Healthcare Facilities from all legal liability that might arise from the release of the information requested. This authorization will be effective for six months or until (date) _____ ***unless terminated in writing.***

_____ _____ _____

Signature of Patient or Guardian Relationship to Patient Date