



Charles Drew

HEALTH CENTER, INC.

"Growing a Healthy Community"

Office Use Only

Info for Dr.: _____ MR#: _____ Initials: _____

Picked-up Date: _____ Faxed Date: _____

Mailed Date: _____

Date Requested: _____ Date Needed: _____

Call when ready? Yes No

Method of Delivery (check one)

Pick-up Mail Fax Other

Please allow 7-10 business days to process request

RELEASE OF INFORMATION

Charles Drew Location

- Grant Street, Belvedere Elementary, Northwest High School, Evans Tower, Omaha Healthy Start, St. Richards, Kellom Elementary, Crown Tower, Florence Tower, Fathers for a Lifetime, Siena Francis, King Science Middle School, Jackson Tower, 30 Metro

Patient Information

Patient Name, Date of Birth, Previous Name, Phone, SSN/ID#, Address

Authorization

Choose ONLY one authorization

- I hereby authorize my records from Charles Drew Health Center for disclosure to:
I hereby authorize my records be sent from:

Charles Drew Health Center 2915 Grant Street, Omaha NE 68111 | Phone: (402) 451-3553 | Fax: (402) 453-1970

Dates of Service From: _____ To: _____

Information to be disclosed

- Abstract: Notes and/or Labs, The entire health record including alcohol and substance testing or treatment, HIV/AIDS status or related information and Reproductive Health, Discharge Summary, H/P, Labs ONLY, Radiology, Immunizations, Complete medical records, including progress notes, visit notes, labs and X-ray reports.

Specific authorization for Release of Information protected by State or Federal Law

- Mental health testing, counseling and treatment information, Chemical dependency (drug and alcohol), STD/HIV, Other:

For purpose of: Continuity of care Personal reasons Legal reasons Moving Transfer of care Other

Signature of patient or legal guardian, Date, Relation to patient (if not self):

EXPIRATION: This authorization is effective for 12 months but no longer than one year from the date on which it was signed.

Note: A parent or legal guardian must sign if patient is a minor (NE - under age 19, IA - under age 18) except for reproductive health and HIV testing. If signed by a patient's authorized representative, supporting legal documentation must accompany this form. Notice to Recipient: The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted (42CFR Part 2). A general authorization for release of protected health information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.