



Authorization for Use and/or Disclosure of Confidential Information
Make sure all information is complete. Please print. * indicates required fields.

*Patient Name: _____ *Date of Birth: _____

*Address: _____

Telephone Number: _____ Previous Name (if applicable) _____

(circle one)

***This will authorize:**

Allergy, Asthma, and Immunology Associates, PC
600 N Cotner Blvd STE 208
Lincoln, NE 68505
(P) 402-464-5969 (F) 402-464-3657

***Disclose To**

***Receive From**

p# _____ f# _____

***The following information:**

- Records from the last 1, 2, or 3 yrs (circle one)
- Lab/radiology reports
- Complete medical records
- Other _____

Reason for Release

Signature of Patient or Legal Guardian

(Needed for minors-NE under age 19, IA under age 18)

Relationship (if not patient)

Date

Office Use Only

Copied by: _____ Date: _____

To be sent (date): _____

To be picked up (date): _____

Picked up on (date): _____

Released by: _____

Released to: _____