Accepted By: _____ Staff Initials
Received from: __ Medical ___ Dental

Check if entered into Smart sheet:_____
Method of Release Mail: _____ Pickup: _____ Fax: _____

BLUESTEM HEALTH
1021 N 27th St Lincoln, NE 68503 | Phone: (402) 476-1455 | Fax: (402) 476-1655

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print request in black/blue ink, include either address or fax number.

_____ _____
Patient Name Date of Birth

Release Information From:	**Release Information to:**
Bluestem Health Medical Records	Name:
1021 N. 27th Street Lincoln, NE 68503	Address:
Phone: 402-476-1455	Phone:
Fax: 402-476-1655	Fax:

Purpose/Reason for Release: _____

Release the following information:

☐ Entire Medical Record ☐ Lab Reports ☐ Immunizations

☐ Medication Record ☐ Dental Records ☐ Other(Specify Below)

I consent to the release of health records including HIV/AIDS status and alcohol/substance abuse treatment/testing
Initials: Date: _____

By signing this form, I authorize the above facility/provider/person/entity to disclose medical information concerning the above named patient to the party identified in the section titled "Release Information to". I understand that I may revoke this authorization at any time in writing or it will automatically expire 12 months from the date signed below. My signature indicates that I am authorized to obtain or release records on the above named patient. I understand that once my records are released, there's no guarantee preventing re-disclosure.

Patient Signature: _____**Date:** _____

Parent: _____ **Relationship to patient:** _____ **Date:** _____

Revised: 12/12/2019