Nebraska Urgent Care Center

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4720 W. Huntington Ave. Suite J
Lincoln, NE 68524
Phone: 402-470-6055
Fax: 402-470-6056

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Last 4 digits of SSN:_____

I request and authorize _____
to release health care information of the patient named above to: Nebraska Urgent Care Center at:

4720 W. Huntington Ave. Suite J
Lincoln, NE 68524
Phone: 402-470-6055
Fax: 402-470-6056

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____
_____

☐ All healthcare information

☐ Other: _____

Authorization to release STD*, drug and alcohol and/or mental health treatment information:

☐Yes ☐No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s)/facility listed above. I understand that the person(s)/facility listed above will be notified that I must give specific permission before disclosure of these test results to anyone.

☐Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s)/facility listed above.

*Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma, venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Patient Signature:_____ Date:_____

THIS AUTHROIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED