4242 Farnam St. Suite 360, Omaha, NE 68131, 402-552-2555 Fax 402-552-2598
John R. Luckasen, MD – Jason S. Papenfuss, MD, Justin G. Madson, MD, PhD, Melissa D. Darling, MD

Authorization to Use and/or Disclose Protected Health Information

Patient: ____ Date of Birth: __________________

Phone # ______________________________

I authorize and request employees of **Midwest Dermatology Clinic, PC** to release the stated information to the specified parties named below. I understand that this authorization will be considered valid and active for six months upon which time it will be inactivated. I understand I have the right to revoke this authorization in writing at any time. I understand that the revocation will not apply to those disclosures that have already been made.

Reason for release (may use "per my request") ______________________________

Please include the following information:

Complete Medical records ________
Blood Test results ______ from (date) __________to _________
Pathology Test Results _______ from (date) __________ to_________

Other ____
Including, if applicable, the following information related to testing, diagnosis, and/or treatment for (please initial applicable line): _____HIV (AIDS virus), ____sexually transmitted diseases, ____mental health, or ____drug/and or alcohol abuse.

Requesting the Release From

Midwest Dermatology Clinic, P.C.

____
(Physician Name)

Information to be released to:

To: ____

Address: ____

City: ___________________________ State: ___________ Zip:_______________

Signature ____ Date _______________

Witness ____________________________________ Relationship to Patient _____________

updated November 2020