PRIMARY CARE PHYSICIANS

12728 Augusta Avenue
Omaha, NE 68144
402.330.1410

Medical Information Release Form

HIPAA Release Form

Patient Name: ______________________ **DOB:** ____________________ **MRN:** ____________

Check the following option you would prefer for Release of Information:

- o I authorize the release and discussion of my information to the following person(s):

Name **Relationship** **Phone #**

Name **Relationship** **Phone #**

- o I do **NOT** authorize the release or discussion of my information to anyone.

If you chose the option to not authorize release or discussion of information, we will be unable to talk to anyone but yourself about your medical and billing records

- I hereby authorize Primary Care Physicians to furnish to the insurance company all information which said insurance company may request concerning my present illness or injury. Information may also be disclosed to the referring physician or to other health care providers, facilities, or agencies that I may be referred to. I hereby assign to Primary Care Physicians the amount of money to which I am entitled for medical and/or surgical expenses for each claim submitted
  - o **Initial**:_______
- I acknowledge receipt of the Notice of Privacy Practices
  - o **Initial**:_______
- I acknowledge receipt of the Payment and Billing Policy and agree to those conditions of payment
  - o **Initial**:_______

Signature of Patient: ______________________________ **Date:** ______________

Signature of Patient Representative: ______________________ **Printed Name:** ______________

Signature of Witness: ____