CREIGHTON UNIVERSITY
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

By signing this form, you permit Creighton University to release your health records described below. You are responsible for copying costs. *The cost is $.50 per page*; additional charges apply to films/tapes.

A. **Patient**. The patient whose information may be released is:

NAME _____ **DOB** _____

ADDRESS _____ **SOCIAL SECURITY NUMBER** _____

B. **Records**. I am authorizing release of the following health information (check as applicable):
☐ Dates of Service ☐ Entire Medical Record ☐ Other: _____

_____ _____

C. **Special Instructions**.
☐ Please release / ☐ Please do not release drug and alcohol testing or treatment information, if any.
☐ Please release / ☐ Please do not release HIV/AIDS test results, if any.

D. **Releasing Department**. The departments authorized to release these records are (check all that apply):

❑ Creighton Dental Clinic ❑ Creighton Pediatric Therapy ❑ Creighton Specialty Pediatrics

❑ Creighton Clinic Pharmacy ❑ Creighton Therapy and Wellness

E. **Recipient**. I give permission to Creighton to release the above records to:

NAME _____

ADDRESS _____

F. **Purpose of Release**. The reason I am authorizing release is: ☐ My Request ☐ Other (describe): _____

G. **Expiration**. This authorization expires 6 months from the date or Date/Event: _____

H. **Explanation of Rights**. I, as the patient/patient representative, understand that:

- I have the right to revoke this authorization at any time. I must give my written revocation to: Creighton University, Attn: University Privacy Officer, 2500 California Plaza, Omaha, NE 68178. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
- Creighton may not condition treatment, payment, enrollment in its employee health plan or eligibility for benefits on whether I sign this authorization.
- I have the right to review my health record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health record.
- I am authorizing disclosure of information protected by federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
- A separate authorization is required for the release of psychotherapy notes.

I. **Authorization**. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Signature of Patient/ Personal Representative Date

_____ _____
Representative's Relationship to Patient (if applicable) Representative's printed name