

**Women's Healthcare Center of Williamsburg**

**CONSENT TO RELEASE HEALTH INFORMATION**

Patient Name \_\_\_\_\_

Other Name(s) Used \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_

Social Security # \_\_\_\_\_

Phone # \_\_\_\_\_

I hereby authorize: \_\_\_\_\_ (name of agency/person)

\_\_\_\_\_ (address)

\_\_\_\_\_ (phone #) \_\_\_\_\_ (fax #)

To Release Medical Information to: **Women's Healthcare Center of Williamsburg**  
**6050 Village Drive**  
**Lincoln, NE 68516-4732**  
**(402) 421-8581 office (402) 421-8594 fax**

Describe Information to be Released: \_\_\_\_\_

For the Purpose Of: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

- Individual
- Parent (if individual is under the age of 19)
- Legal Guardian

**SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY FEDERAL LAW**

I specifically authorize the release of data and information relating to: (circle appropriate response)

- |   |     |    |                |
|---|-----|----|----------------|
| 1. Substance abuse (alcohol/drug abuse)           | Yes | No | Does Not Apply |
| 2. Mental Health                                  | Yes | No | Does Not Apply |
| 3. HIV Related Information (AIDS related testing) | Yes | No | Does Not Apply |

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

I understand that you have no responsibility for the use of distribution of this information by the party to whom it is released. I release you from all liability, which may arise from your compliance with this request to release records. I authorize you to transmit this information by facsimile transmission (fax), and release you from any liability for breach of confidentiality, misdirection of transmission or failure to receive transmission if my records are transmitted by facsimile (fax).