

Coddington Medical Family Practice

1336 West A Street, Suite A, Lincoln, NE 68522

Ph (402) 438-0101

Fax (531) 278-1213

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

My Authorization: You may use or disclose the following health care information (check all that apply):

- All my health information for the last year
- My health information for the dates: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases, drug and alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Authorize Information Released From:	Please Send My Records To:
Coddington Medical Family Practice	
1336 West A Street, Suite A	
Lincoln, NE 68522	
P) 402-438-0101 F) 531-278-1213	

Reason for this authorization: _____

This form is valid for 180 days. Patient retains the right to revoke this authorization at any time.

Patient Signature

Date

Printed name and relationship to patient if signing on behalf of patient