SEND FORM TO:
Think Medical Records Department
7100 West Center Rd, Omaha, NE 68106
T: 402-506-9000 | Fax: 402-506-9093 | medical.records@thinkhealthcare.org

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Type of Information to be Disclosed

Check applicable
Office Visits, Specify (Dates _________)
○ Imaging or Labs (Dates _________)
○ All medical information in record**
○ Immunizations
○ Other, Specify:
____
____

****Important Note**
Your medical record may include ***highly sensitive*** information (e.g. mental health records, records of drug or alcohol abuse, HIV, STDs, or other sensitive diagnoses). By selecting this option, you agree to release this information as well.

By law, Think cannot release Psychotherapy Notes with the same authorization form used for other medical records. If these notes are needed, please use our Psychotherapy Notes Release Form.

Patient Information

I request access as the ○ Patient ○ Parent ○ Guardian, Representative, or POA *(documentation required)*

Name of Patient *(print clearly)* | SSN | Date of Birth

Address | City, State, Zip Code | Contact Phone Number

Manner of Information Requested: ***(charges may apply)***

○ Paper ○ CD Copy ○ Referral to Specialist ○ Transfer to New Primary Care

Recipient or Sender Information ***(select one side or the other)***

SEND medical information TO *(Check ○ if same as the above)*	RECEIVE medical information FROM *(Only use if sending information to Think ○)*
Name of Person or Entity *Receiving*	Name of Person or Entity *Sending*
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Telephone and Fax, if necessary	Telephone

By signing below I authorize Think to release all medical information in the way that I have indicated on this form. I understand that I may revoke this authorization at any time in writing, subject to Think's Notice of Privacy Practices. I understand that I can refuse to sign this form and still receive treatment. I understand that Think cannot guarantee the recipient will not inappropriately re-disclose this information. I agree that this authorization will expire one (1) year after the date of signing, or after this date or event ____________________.

Signature of Patient or Representative | **Date** | **Name, Relationship** ***(if not the patient)***

FOR OFFICE USE ONLY

Date received: **Approved by:** **If denied, reason:**