CONSENT TO RELEASE INFORMATION TO POPE PAUL VI INSTITUTE

Patient Name_______________________________________ Other Names Used______________________________
Address____ Date of Birth__________________________________
Phone number ______________________________________ Social Security #_______________________________

I hereby authorize:

____
Name of Person/Agency from whom information is requested

____
Address of Person/Agency

To release medical information to:

Pope Paul VI Institute
Medical Records
6901 Mercy Road
Omaha, NE 68106

____
Signature of Patient or Legal Guardian Date

Medical information to be released to include the following:

- ❑ Lab Results dated ______________________
- ❑ Progress Notes dated_____________________
- ❑ Complete Medical records_________________
- ❑ Other___________________________________
  ____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information related to:

Substance abuse (alcohol/drug abuse)	Yes _____	No______	not applicable_____
Mental Health	Yes_____	No______	not applicable_____
HIV-Related Information (AIDS related testing)	Yes_____	No______	not applicable_____

____
Signature of Patient or Legal Guardian

This authorization for release of information shall remain in effect no longer than ninety (90) days.

This information may have been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.