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CANCER PARTNERS RELEASE FORM

Name _____ DOB ____/____/____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Following the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I authorize with my initials below.
- I have the right to revoke this authorization at any time by writing the health care provider below. I understand that I may revoke this authorization, except to the extent that action has already been taken based on this authorization.
- I understand that signing this authorization is voluntary.

I hereby authorize:

To release medical information to: (Name/Agency requesting medical information)

Cancer Partners of Nebraska

Include: (indicate by initialing)

Complete Medical Records

Alcohol/Drug Treatment Information

Lab/Pathology Results

Mental Health Information

Progress Notes

*HIV-Related Information

Hospital Records

Genetic Testing

Correspondence

Radiology

Signature _____

Date _____

Witness _____

Date _____