

**CREIGHTON UNIVERSITY / CREIGHTON UNIVERSITY MEDICAL CENTER  
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

By signing this form, you permit Creighton University/Creighton University Medical Center to release your health records described below. You are responsible for copying costs. *The cost is \$.50 per page; additional charges apply to films/tapes.*

A. **Patient.** The patient whose information may be released is:

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **SOCIAL SECURITY NUMBER** \_\_\_\_\_

B. **Records.** I am authorizing release of the following health information (check as applicable):

Dates of Service       Entire Medical Record       Other: \_\_\_\_\_

C. **Special Instructions.**

Please release /  Please do not release drug and alcohol testing or treatment information, if any.  
 Please release /  Please do not release HIV/AIDS test results, if any.

D. **Releasing Department.** The departments authorized to release these records are (check all that apply):

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Creighton Dental Associates                       | <input type="checkbox"/> Creighton Family Healthcare | <input type="checkbox"/> Medicine                      | <input type="checkbox"/> Neurology                          |
| <input type="checkbox"/> Creighton Dental Clinic                           | <input type="checkbox"/> Dundee                      | <input type="checkbox"/> General Internal Medicine     | <input type="checkbox"/> ObGyn Women's Health Center - East |
| <input type="checkbox"/> Creighton Oral & Maxillofacial Surgery Associates | <input type="checkbox"/> Eagle Run                   | <input type="checkbox"/> Allergy/Immunology            | <input type="checkbox"/> ObGyn Women's Health Center - West |
| <input type="checkbox"/> Creighton Clinic Pharmacy                         | <input type="checkbox"/> Florence                    | <input type="checkbox"/> Cardiology/Cardiac Center     | <input type="checkbox"/> Pain Clinic                        |
| <input type="checkbox"/> Creighton Medical Laboratories                    | <input type="checkbox"/> John Galt                   | <input type="checkbox"/> Columbus Clinic               | <input type="checkbox"/> Pediatrics                         |
|  | <input type="checkbox"/> South / L Street            | <input type="checkbox"/> Dermatology                   | <input type="checkbox"/> Psychiatry                         |
|  | <input type="checkbox"/> Old Market                  | <input type="checkbox"/> Endocrinology/Diabetes Center | <input type="checkbox"/> Radiology Outreach                 |
|  | <input type="checkbox"/> Twin Creek                  | <input type="checkbox"/> Gastroenterology              | <input type="checkbox"/> Surgery                            |
|  | <input type="checkbox"/> Hereditary Cancer Institute | <input type="checkbox"/> Hematology/Oncology           | Other : _____   |
|  |  | <input type="checkbox"/> Infectious Disease            |   |
|  |  | <input type="checkbox"/> Nephrology / Renal            |   |
|  |  | <input type="checkbox"/> Pulmonary Medicine            |   |
|  |  | <input type="checkbox"/> Rheumatology                  |   |

E. **Recipient.** I give permission to Creighton to release the above records to:

**NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

F. **Purpose of Release.** The reason I am authorizing release is:  My Request  Other (describe): \_\_\_\_\_

G. **Expiration.** This authorization expires 6 months from the date or Date/Event: \_\_\_\_\_

H. **Explanation of Rights.** I, as the patient/patient representative, understand that:

- I have the right to revoke this authorization at any time. I must give my written revocation to: Creighton University, Attn: University Privacy Officer, 2500 California Plaza, Omaha, NE 68178. Revoking this authorization does not affect disclosures already made by Creighton or disclosures otherwise required by law.
- Creighton may not condition treatment, payment, enrollment in its employee health plan or eligibility for benefits on whether I sign this authorization.
- I have the right to review my health record before signing this authorization. Creighton's Notice of Privacy Practice explains how to request access to my health record.
- I am authorizing disclosure of information protected by federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
- A separate authorization is required for the release of psychotherapy notes.

I. **Authorization.** I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

\_\_\_\_\_  
Signature of Patient/ Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative's Relationship to Patient (if applicable)

\_\_\_\_\_  
Representative's printed name