miracle hills clinic
health & wellness

11819 Miracle Hills Dr. Ste 105
Omaha, NE 68154

402-905-2075 **402-905-9864**

MEDICAL RECORDS AUTHORIZATION FOR DISCLOSURE OF INFORMATION

PATIENT NAME:			
ADDRESS:		**DOB:**	
CITY/STATE/ZIP:		**PHONE:**	

The following organization/recipient can receive my health information from Miracle Hills Clinic:

Clinic name/Provider name:			
Address:		**City/State/ZIP:**	
Phone:		**Fax:**	

Information to be disclosed to Miracle Hills Clinic *(check all that apply)*:

☐ All medical records ☐ Labs ☐ X-ray/Imaging
☐ My health information relating to the following treatment or condition:

_____

I understand that the information to be released may include material that is protected by Federal/State law covering substance abuse, mental health and/or AIDS related information *(check if applicable):*

☐ Mental Health information ☐ HIV/AIDS screening results or diagnosis
☐ Suspected Sexual Assault information ☐ Treatment for alcohol and/or drug abuse

If the patient is a minor, please complete the following:

☐ **Patient is a minor:** _____ **years of age** *(NE: under the age of 19, IA: under the age of 18)*

Signature of Authorized Representative: _____
☐ Parent ☐ Legal Guardian ☐ Court Order (you may be asked to provide documentation)

I understand that I have the right to revoke this authorization, in writing, at any time; except where uses and/or disclosures have already been made based upon my original permission. I understand that if I wish to revoke this Authorization I must do so in writing and present the written revocation to the appropriate disclosing party. This Authorization will expire 12 months from the date below

Signature of Patient or Legal Representative: _____

Printed name of Patient or Legal Representative: _____

Date: _____