

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means. Urgent Care of Nebraska may need to contact you regarding test results, appointments, referrals or billing/insurance information. To maintain patient confidentiality and follow federal guidelines we offer the option of signing a **release of information form**. This would allow us to leave information on an answering machine or voice mail at any phone number(s) of your choice. By signing this form below gives permission to have the staff of Urgent Care of Nebraska to leave information about lab/test results over the phone, via fax, via mail or to the person(s) authorized in the event that you do not answer the phone.

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Please fill in the information below that best describes you. We appreciate your participation. Thank you  
\_\_\_ White \_\_\_ Black or African American \_\_\_ Asian \_\_\_ Hispanic \_\_\_ American Indian or Alaska Native  
Language: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_

**Patient or Responsible Party Contact Information:**

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

**If you provided us with your email address, a link will be sent for your convenience to access your records, statements & payments through Patient Portal**

**May release information to a family member, Doctor or others listed:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Primary Care Provider:** \_\_\_\_\_

**Release of Information**

I understand and agree that any phone numbers or email addresses provided by myself to Urgent Care of Nebraska and to any of their service providers, now and in the future, may be used as a means to contact me, and that Urgent Care of Nebraska and their service providers may leave messages for me manually and by voice mail. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

**HIPAA CONSENT OF PRIVACY**

I acknowledge that I have been given the opportunity to read and review Urgent Care of Nebraska's **Notice of Privacy Practices**. By signing this form I consent to the use and disclosure of protected health information (PHI) for treatment, payment or healthcare operations.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or Legal Guardian)