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 & Family Medicine 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 & Family Medicine 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

Patient's Name:____**DOB:**__________

Patient or Responsible Party Contact Information:

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 Health Portal

Email:____

***May electronically share or retrieve my health records through the Nationwide Health Information Exchange** ☐ **Yes** ☐ **No**

***May release (by fax) Excuse From Work/School Note to employer or school nurse** ☐

***May release information to a family member, friend or partner**

Name:____Relationship:______________

Release of Information

I understand and agree that any phone/fax numbers or email addresses provided by myself to Urgent Care & Family Medicine of Nebraska (UCON) and to any of their service providers, now and in the future, may be used as a means to contact me, and that UCON 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 & Family Medicine of Nebraska **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)