Village Pointe Pediatrics, P.C.
18018 Burke Street
Elkhorn, NE 68022
Phone (402) 573-7337
Fax (402) 614-2314

Dundee Pediatrics
5018 Underwood Ave., Ste 200
Omaha, NE 68132
Phone (402) 991-5678
Fax (402) 991-5358

village pointe | dundee pediatrics

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

I hereby authorize and request release of medical records:

FROM		**TO**	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	
Phone		Phone	
Fax		Fax	

Date(s) of service requested: From (date) _____ To (date) _____

Information to be disclosed/released:

- ☐ Complete Record
- ☐ Progress Notes/Growth Charts
- ☐ Immunization Records
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ Laboratory/Pathology Results
- ☐ Emergency Room/Urgent Care Reports
- ☐ History and Physical Examinations

Purpose of release:

☐ Continuing Medical Care	☐ Personal Records	☐ Legal	☐ Other _____

Method of Delivery: (Village Pointe Pediatrics does not email medical records)

☐ In-Person Pick Up	☐ Mail Delivery	☐ Fax	*Village Pointe Pediatrics is not responsible for copies of records once they have been mailed.

By Signing this Authorization form, I understand that:

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.
- Unless otherwise revoked, this authorization remains valid for 6 months.
- I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations.
- I am aware all efforts will be made to expedite my request in a timely manner. According to State regulations I am aware that Village Pointe Pediatrics may take up to 30 working days to process this request.

_____ _____

Signature of Parent, Guardian, or Legal Authorized Representative | Relationship to Patient

_____ _____

Printed Name | Date

STAFF ONLY	