Please note: If any section is incomplete, the form becomes invalid.

<table>
<tr><td rowspan="4">Patient:</td><td>Name:</td></tr>
<tr><td>Address:</td></tr>
<tr><td>City: State: Zip:</td></tr>
<tr><td>Date of Birth: Phone:</td></tr>
<tr><td rowspan="5">Provide address of previous Physician:</td><td>I authorize the following facility/provider to release my health information upon my request:</td></tr>
<tr><td>Name:</td></tr>
<tr><td>Address:</td></tr>
<tr><td>City: State: Zip:</td></tr>
<tr><td rowspan="4">Health Information disclosed to:</td><td>I authorize my health information be disclosed to :</td></tr>
<tr><td>Hart Family Health Phone: (402) 488-5972</td></tr>
<tr><td>8101 O Street, Suite 120 Fax: (402) 488-5974</td></tr>
<tr><td>Lincoln, NE 68510</td></tr>
<tr><td rowspan="8">Health information to be disclosed:</td><td>Please note: If dates are not provided, only the past two years will be provided.</td></tr>
<tr><td>Yes No Copies of clinical notes From (date) To (date)</td></tr>
<tr><td>Yes No Copies of hospital records From (date) To (date)</td></tr>
<tr><td>Yes No Lab records From (date) To (date)</td></tr>
<tr><td>Yes No Radiology reports From (date) To (date)</td></tr>
<tr><td>Yes No HIV/AIDS testing/treatment From (date) To (date)</td></tr>
<tr><td>Yes No Alcohol/Drug abuse eval From (date) To (date)</td></tr>
<tr><td>Yes No ALL of the above / Other From (date) To (date)</td></tr>
<tr><td>Reason for request</td><td>____Consult/second opinion _____Disability _____ Legal
_____Change of doctor _____Personal _____Other</td></tr>
<tr><td>Revocation</td><td>I understand that I have the right to revoke my authorization at any time. I understand that if I revoke this authorization, that I must do so in writing and present my written revocation to the Privacy Officer. I understant that the revocation will not apply to my insurance company when the law provides my insureer with the right to consent a claim under my policy.
I understand that this authorization will be in effect for 90 days from the date signed unless revoked by me in writing.</td></tr>
<tr><td rowspan="3">Authorization</td><td>I understand that authorizing the release of this information is voluntary, I understand that I may have to access to my health information. I understand that any release of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that Hart Family Health is not responsible for electronic or paper records re-disclosure once the records have been released to the patient or facility.
Please allow up to 30 days to process the release. Copying fee: $20 + .50 per page may apply. (personal and legal reasons).</td></tr>
<tr><td>Patient Signature (age 19 and older must sign or legal guardian) Date:</td></tr>
<tr><td>Relataionship to patient/authority Date:</td></tr>
</table>