UNIVERSITY OF Nebraska

Claim Number:

GALLAGHER BASSETT SERVICES, INC.
AUTHORIZATION FOR RELEASE OF INFORMATION
(HIPAA COMPLIANT)

Patient Information:

________________________________ BD: ____________ SS# ________________
(Print Name of Patient)

Information to be released from: ____
Name of Designated Facility or Provider

____
Address

________________________ ________________
City, State, Zip Code Phone Number

Information to be sent to:

GALLAGHER BASSETT SERVICES, INC.
ATTN: Resolution Manager
Name of Designated Recipient

PO Box 2934
Address

Clinton, Iowa 52733 402-972-4785
City, State, Zip Code Phone Number

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- ☐ All medical records
- ☐ Specific information (Please specify) _

Purpose for which disclosure is being made: Processing of an insurance claim.
Date of Loss: _____

Claim Number:

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*** EXCLUDE the following information from the records released (please initial):**

____	Drug/Alcohol abuse /treatment & diagnosis	____	Sexually Transmitted Disease
____	HIV/AIDS diagnosis/treatment/ testing	____	Mental Illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ______________________________________ DATE: ____________

(Patient, Guardian*, or Authorized Representative*)
[*Please provide documents to prove authority to sign on behalf of the patient]

SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE
PHOTOCOPY VALID AS ORIGINAL