RECORDS RELEASE REQUEST

BRADDOCK FINNEGAN DERMATOLOGY, P.C.

7911 West Center Road | Omaha, NE 68124
Phone# (402)390-0333 Fax# (402)390-9632

Please choose from the following:

( ) TO ( ) FROM

( ) **Mary Finnegan, M.D.**
( ) **Blake Helget, M.D.**
( ) **Greg Morrison, PA-C, MPAS**
( ) **Joyce Sumner, PA-C, MPAS**
( ) **Molly Hughes, PA-C, MPAS**

Patient Name: _____ Date of Birth: _____

Address: _____

City, State and Zip: _____

I hereby request that copies of the following records be sent

( ) TO ( ) FROM

Name: _____

Address: _____

City, State and Zip: _____

Reason for Request

( ) **Transfer of Care** (leaving our practice)
Reason for leaving:_____
**If no purpose is stated, then the purpose of the disclosure will be "at my request"*

( ) **Continuity of care/2nd Opinion** (info to PCP)

( ) **Self/Insurance**

Specific Records

( ) **All Medical Records**
**To include HIV/AIDS if any*

( ) **Pathology Reports**

( ) **Lab Reports**

( ) **Other:**_____

I understand this Authorization may be revoked at any time, except to the extent that action has already been taken in reliance on this Authorization. I understand that if I wish to revoke this Auhtorization, I must do so in writing and present my written revocation to the medical records department or custodian with whom the original Authorization was submitted.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____

If I fail to specify an expiration date, event or condition, this Authorization will expire twelve (12) months from the date below.

Patient Signature or Legal Guardian (if child is a minor):_____

Date:_____