I authorize _____ to release the following

information on _____

Patient's Name/Date of Birth/Last 4 digits of Social Security Number

to Bruce Dart, Health Director & Jim Weverka, Animal Control Manager
Lincoln Lancaster County Health Department
3140 N St., Lincoln, NE 68510 (402)441-7900

1. Date(s) of information to be disclosed: _____,_____ through _____,_____

2. Information to be disclosed during designated dates: _____
   Emergency Department Report

3. Purpose for which information is to be used:
   Follow-up & investigation of bite to determine status of dog (quarantined, potentially dangerous dog, dangerous dog, vicious animal).

4. I understand that I may revoke this authorization at any time by submitting a written request to _____, however to the extent that action has already been taken, a revocation will not be possible. Without my permission to revoke this authorization and except as otherwise provided herein, it will automatically expire on the sooner of; after six (6) months from the date of signature, or upon satisfaction of the need for disclosure, or as specified.

5. I understand and agree that _____ cannot control the re-disclosure by the recipient of the information disclosed to them, provided, however, that Alcohol, Chemical and Drug Abuse Patient Records which are disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.

6. I hereby release _____ from all legal liability that might arise from their release of the information or the re-disclosure of the information by the recipient. I consider a photocopy of this authorization to be as valid as the original.

7. Future treatment or payment will not be conditioned by the signing or not signing this authorization.

8. I understand that I may upon written request inspect the information to be disclosed.

Authorization must be signed by the patient or legal guardian of the patient, or other authorized representative. If patient is unable to give authorization, or physically sign, state reason:

_____

_____ _____
Patient or Person Authorized to Consent for Patient/Relationship Date/Time

_____
Street

_____
City State Zip

_____ _____
Animal Control Witness to Signature Only Person Disclosing Records

Lincoln-Lancaster County Health Department
Animal Control
Lincoln, NE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Original - Medical Record Yellow - Patient/Designee
medical release.cdr 5/03