NOH063

OrthoNebraska

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please mark where records are being released from:

☐ **OrthoNebraska Hospital**	☐ **OrthoNebraska Clinic**	☐ **Rheumatology Clinic**	☐ **Other Facility/Provider**
2808 South 143rd Plaza Omaha, NE 68144 Fax (402) 609-2121 Phone (402) 609-2100	2725 South 144th Street STE 212 Omaha, NE 68144 Fax (402) 609-2174 Phone (402) 609-2150	2727 South 144th Street STE 240 Omaha, NE 68144 Fax (402) 609-2121 Phone (402) 609-2100	Name Address Phone Fax

Purpose of Release: ☐ Patient Request ☐ Insurance ☐ Social Security Benefits/Claim
☐ Continued Care ☐ Attorney ☐ Other_____

I hereby authorize the above checked Facility(s) to release the following information from the records of:

Patient Name:_____ **Date of Birth:**_____

Address:_____

City/State/Zip:_____

Daytime Telephone where you can be reached:_____

Information to be Released:

The information will be released to:

_____
(Name of provider, other person, or organization)

_____
(Street Address) **(City)** **(State)** **(Zip)**

Release Format: ☐ Paper ☐ Other_____ *Radiology images will be released on a separate CD

Release Method: ☐ Mail ☐ Other_____

Covering the date(s) of service: From_____To_____

HOSPITAL Information to be Disclosed

☐ Discharge Summary ☐ Operative Reports
☐ History and Physical ☐ Laboratory Reports
☐ Radiology Reports ☐ Radiology Images
☐ Physical/Occupational Therapy Notes
☐ Emergency Report
☐ Other_____

CLINIC Information to be Disclosed

☐ Physician Clinic Notes/Doctor_____
☐ Operative Reports ☐ Infusion Records
☐ Radiology Reports ☐ Radiology Images
☐ Billing ☐ EMG
☐ Other_____

Information Protected by State and Federal Law. I understand that the information in my health record may include information relating to behavioral or mental health services, treatment for alcohol and/or drug abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or self-paid services. I authorize the release of this information to the party listed above, unless specifically excluded on the line below:
Exclusions:_____

This Authorization can be revoked at any time before disclosure of the information, and expires on the following date, event or condition: _____. **If no expiration date or event related to the individual is listed, then the Authorization will expire 12 months from the date on which it was signed.** I understand that I may revoke this Authorization at any time by notifying OrthoNebraska Hospital or OrthoNebraska Clinics in writing at the address(es) listed above. If I revoke the Authorization, it will not have any effect on actions taken prior to receipt of the revocation. I understand that the individual/entity 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 understand that the OrthoNebraska and its affiliates will not condition evaluation or treatment on whether I sign this Authorization. Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

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

Fulfilled by OrthoNebraska Staff: **Name**_____ **Date**_____