



Please mark where records are being released from:

<input type="checkbox"/> OrthoNebraska Hospital 2808 South 143 rd Plaza Omaha, NE 68144 Fax (402) 609-2120 Phone (402) 609-2100	<input type="checkbox"/> OrthoNebraska Clinic 2725 South 144 th Street STE 212 Omaha, NE 68144 Fax (402) 637-0814 Phone (402) 637-0856	<input type="checkbox"/> Rheumatology Clinic 2727 South 144 th Street STE 240 Omaha, NE 68144 Fax (402) 609-1220 Phone (402) 609-1200	<input type="checkbox"/> Other Facility/Provider Name _____ Address _____ Phone _____ Fax _____
Purpose of Release:			
<input type="checkbox"/> Continued Care	<input type="checkbox"/> Patient Request	<input type="checkbox"/> Insurance	<input type="checkbox"/> Social Security Benefits/Claim
	<input type="checkbox"/> Attorney	<input type="checkbox"/> 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 In-Person Pick Up Other _____

Covering the date(s) of service: From _____ To _____

<p><u>HOSPITAL Information to be Disclosed</u></p> <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Operative Reports <input type="checkbox"/> History and Physical <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Physical/Occupational Therapy Notes <input type="checkbox"/> Emergency Report <input type="checkbox"/> Other _____	<p><u>CLINIC Information to be Disclosed</u></p> <input type="checkbox"/> Physician Clinic Notes/Doctor _____ <input type="checkbox"/> Operative Reports <input type="checkbox"/> Infusion Records <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Billing <input type="checkbox"/> EMG <input type="checkbox"/> Other _____
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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 _____