MEDICAL RECORDS RELEASE

PATIENT IDENTIFICATION	Name: _____ Last First MI Date of Birth: _____ / _____ / _____ Maiden / Other Names Known By: _____
CONTACT INFORMATION (For Patient)	Address: _____ City: _____ State: _____ Zip: _____ Day Phone: _____-_____-_____ Evening Phone: _____-_____-_____
RELEASE RECORDS TO (Recipient)	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Day Phone: _____-_____-_____ Fax: _____-_____-_____
INFORMATION REQUESTED	☐ **What Body Part?** _____ ☐ All Records ☐ Medical Records ☐ Films ☐ Billing Statement Only Other: _____ Dates to be Included: _____
PURPOSE OF RELEASE	☐ Legal ☐ Changing Physicians ☐ Continuing Care ☐ School ☐ Insurance ☐ Workers Compensation ☐ Consultation/Second Opinion ☐ Other (e.g., patient request): _____
TIME LIMIT	This Medical Records Release expires on: ☐ _____ / _____ / _____ **OR** ☐ Twelve (12) months from the date of signing (below)
DISCLOSURES	• You may revoke this Medical Records Release at any time by notifying Nebraska Orthopaedic Center in writing sent to 6900 A Street, Lincoln, NE 68510, and it will be effective as of the date of notification except to the extent that action has already been taken in reliance upon this Medical Records Release. • Your protected health information used or disclosed pursuant to this Medical Records Release may be subject to re-disclosure by the Recipient and no longer protected by Federal privacy regulations. • Treatment of the Patient by Nebraska Orthopaedic Center may not be conditioned on him/her or his/her Parent, Legal Guardian, or other Authorized Person signing this form; however, we cannot release the Patient's medical records (as requested) unless this form has been signed.
SIGNATURES	_____ _____ / _____ / _____ Signature of Patient (or Parent/Legal Guardian/Authorized Person) Date _____ Printed name of person whose signature appears above

******FOR OFFICE USE ONLY******

Date Filled: _____ By: _____ ID: _____