Nebraska Orthopaedic Center, PC
402.436.2086 | **Fax**
402.436.2000 | **Phone**

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 ☐ Release records to recipient ☐ NOC to receive records from facility	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 redisclosure 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: _____

Employee Name: _____

☐ Patient has picked up records

☐ Mail records to patient