



If mailing this form: please send to:  
 Nebraska Orthopaedic Hospital  
 Medical Records Department  
 Attn: Release of Information  
 2808 South 143<sup>rd</sup> Plaza  
 Omaha, NE 68144

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

Patient Name	Medical Record Number
Address	Date of Birth
City/State/ZIP	Phone (        )

I authorize and request \_\_\_\_\_  
 (Person/Physician/Entity TO RELEASE records – please be specific)

to release the following noted protected health information from the medical records of the Patient listed above to:

\_\_\_\_\_  
 \_\_\_\_\_  
 (Name and Address)

- By mail
- By electronic access to medical and claims information
- Through oral communication with healthcare providers regarding treatment, care or payment.

The specific information for the following dates of service: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED** (check the appropriate boxes and include other information where indicated):

- Discharge Summary
- Laboratory Reports
- Operative Report
- All medical records associated with my treatment
- Other \_\_\_\_\_
- History and Physical
- Radiology Reports
- Physical Therapy/Occupational Therapy Notes

**Check if the following applies:** I understand that this will include information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

**THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE:**

- Sharing with other health care providers as needed
- Legal reasons
- Other \_\_\_\_\_
- Insurance Processing
- Personal Use

This Authorization shall cover actions by and for Nebraska Orthopaedic Hospital and all their respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Medical Records Department (see address above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This Authorization will expire on the following date, event or condition: \_\_\_\_\_

**If I fail to specify an expiration date or event, this Authorization will expire six (6) months from the date on which it was signed.**

Signature of Patient		Date
Signature of Parent/Legal Guardian (if Patient is a Minor/Power of Attorney)	Relationship to Patient	Date