Authorization to Obtain and Disclose Information

PATIENT: _____
Last First Middle Maiden

_____ _____
Date of Birth Address City State Zip

REQUEST: I hereby authorize Central Nebraska Spinal Surgery Center P.C. to

816 22nd Avenue, Suite 101
Kearney, NE 68845
Phone (308) 865-2557 Fax (308) 865-1461

☐Disclose to: ☐Obtain from:

Organization _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

PURPOSE OF DISCLOSURE:

☐ Appointment with another physician
Appointment date: _____
☐ Moving out of town
☐ Continuation of care elsewhere
☐ Personal Use
☐ Other_____

MEDICAL RECORDS: I hereby authorize the above-named to disclose/obtain the following medical records.

☐ All medical records ☐ Operative reports ☐ Clinic notes
☐ Radiology reports ☐ Other_____

AUTHORIZATION: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Central Nebraska Spinal Surgery Center, P.C. I understand that the revocation will not apply to information that has already been release in response to this authorization. Unless otherwise revoke, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire six (6) months after the date signed below.

I understand that authorizing the disclosure of this health information is voluntary, and I can refuse to sign this. I need not sign this form in order to ensure treatment. I understand that I may inspect or receive a copy of the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer of Central Nebraska Spinal Surgery Center, P.C.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship (if not the patient)

For Office Use Only
Staff disclosed____
Date disclosed____