Omaha Orthopedic Clinic &
Sports Medicine, P.C.
11704 W. Center Road Suite #200
Omaha, NE 68144
Phone: 402-691-0500 Fax: 402-691-1586

Medical Record Release Authorization

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

I hereby authorize records FROM:

Name:_____

Address:_____

City/State/Zip_____

Phone#_____Fax#_____

To be released TO:

Name:_____

Address:_____

City/State/Zip_____

Phone#_____Fax#_____

This request is being made for the following purpose(s):_____

Date Range_____to_____

☐ Physician Office Notes ☐ Radiology/Xray/MRI/EMG reports ☐ Xray Images

☐ Operative/Procedure Reports ☐ Lab/Path Reports ☐ Other_____

*If you are requesting MRI or CT images done at another facitlity, you will need to contact that facility.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure threatment. I understand that any disclosure disclosure of information carries with it the potential for an authorized redisclosure 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 authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavorial 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 authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) **(Signature or Patient/Parent/Guardian or Authorized Representative)**

This authorization will expire one year from the above date unless I specify and expiration date:_____

(Expiration date of authorization)