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1. Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_  
SSN#: \_\_\_\_\_

2. I hereby authorize and request release of my medical records:

FROM: \_\_\_\_\_  
(Health Care Facility to send information)

TO: \_\_\_\_\_  
(Name of Institution or Individual to receive information)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip)

\_\_\_\_\_  
(Fax Number)

3. Information to be disclosed:

From (Date) \_\_\_\_\_ to (Date) \_\_\_\_\_

- Clinic Notes  Laboratory Results  X-Ray/MRI Images (on a disc)
- X-Ray Reports  Operative Report
- Other (Please specify) \_\_\_\_\_

4. Purpose of Release:  Medical Care  Transferring Care  Attorney  Personal Records  
 Other (Please specify) \_\_\_\_\_

5. This statement of consent can be revoked at any time before disclosure of the information, and expires on \_\_\_\_\_ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

I understand that Central Nebraska Orthopedics and its affiliates will not condition evaluation or treatment on whether I sign this authorization.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Signature of Parent, Guardian, or Authorized Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship of above Person to Patient)

**COPY IS A VALID ORIGINAL**  
**AUTHORIZATION FOR RELEASE OF INFORMATION**