Medical Record No._____

PATIENT IDENTIFICATION	Name:_____ _____ ___ Last First MI Date of Birth:_____/_____/_____ Maiden/ Other names known by:_____
CONTACT INFORMATION	Address:_____ City:_____ State: _____ Zip:_____ Day Phone:_____-____-_____ Evening Phone: _____-_____-_____
RELEASE RECORDS TO: (Person or Place records will be sent)	Name: _____ Address:_____ City:_____ State: _____ Zip:_____ Phone:_____-____-_____ FAX: _____-_____-_____
DATES OF TREATMENT	☐ Medical Records only ☐ Films only ☐ Billing statement only ☐ All Records ☐ ***WHAT BODY PART?*** _____ ☐ Other: _____ Dates to be included:_____
PURPOSE OF RELEASE	☐ Legal ☐ Changing physicians ☐ Continuing care ☐ Insurance ☐ Workers Compensation ☐ School ☐ Consultation/ Second Opinion ☐ Other/ (Please specify):_____
TIME LIMIT **Disclosures**	• I understand that this authorization will expire 180 days after I have signed the form. • I understand that I may revoke this authorization at any time by notifying Lincoln Orthopaedic Center in writing and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. • I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. • I understand that if I am being requested to release this information by_____ (print name of provider) for the purpose of :_____ _____ o By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form. o I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it. o I have been informed that _____(print name of provider) ☐ will / ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information as described above. • I understand that in compliance with Nebraska statute, I will pay a fee of $_____ (print fee charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.
SIGNATURES	_____ ___/___/___ Signature of Patient Date _____ ___/___/___ Or Parent or Legal Guardian/ Authorized person Date _____ ___/___/___ Records Received By Date Relationship to patient_____

FOR OFFICE USE ONLY

Date request filled: _____/____/_____ By:_____