MD WEST | ONE

ORTHO • NEURO • EXCELLENCE

17030 Lakeside Hills Plaza, Suite 200 Omaha, NE 68130
Phone: 402-399-8550 | **Fax:** 402-399-8455

MEDICAL RECORDS REQUEST

Patient: ___________________________DOB: _____________SS#: ______________

Address: ____

Hereby authorizes MD West ONE PC to (check one or both):

- ☐ Release protected health information to:
- ☐ Receive protected health information from:

Name/Office: ____

Address: ____

City/State/ZIP: ____

Fax: ______________________________Phone: ____________________________

Specific information to be disclosed (check all that apply):

- ☐ Medical Records (i.e. office notes, progress reports)
- ☐ Billing Statement
- ☐ Radiology Reports
- ☐ Images (i.e. MRI, X-Ray, CT)
- ☐ Complete Record
- ☐ Verbal Communication Only
- ☐ Other: ____

Date(s) of service to be disclosed: _______________________________________
Specify time frame or "All"

PATIENT RIGHTS REGARDING THIS AUTHORIZATION:
I have the right to inspect or request a copy of this authorization. I understand there is no obligation to sign this authorization and that I may refuse to sign it. I have the right to revoke this authorization at any time by providing written notice to MD West ONE PC. This authorization will expire on ________________ or 1 (one) year after the date signed.

Signed: __________________________________ Date: _____________________
Patient/Legal Guardian

Witness: _________________________________ Date: ______________________