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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Purpose of Release:	<input type="checkbox"/> Patient Request	<input type="checkbox"/> Insurance	<input type="checkbox"/> Social Security Benefits/Claim
	<input type="checkbox"/> Continued Care	<input type="checkbox"/> Attorney	<input type="checkbox"/> Other _____

I hereby authorize the above facility to release the following information from the records of:

Patient Name: _____	Date of Birth: _____
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Address: _____

City/State/Zip: _____

Daytime Telephone where you can be reached: _____

Information to be released TO:

Information to be released **TO:** _____

Information to be obtained **FROM:** _____

ORGANIZATION, DOCTOR OR NAME	ORGANIZATION, DOCTOR OR NAME
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STREET ADDRESS	STREET ADDRESS
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CITY, STATE, ZIP	CITY, STATE, ZIP
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PHONE _____ FAX _____	PHONE _____ FAX _____
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ALL DATES OF SERVICE SPECIFIC DATE RANGE: FROM _____ TO _____

ALL RECORDS NEUROSURGERY ONLY RECORDS ORTHOPEDIC ONLY RECORDS

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

- Complete Record
- Medical Records (i.e office notes, progress notes)
- Radiology Reports
- Radiology Films (i.e. MRI, X-Ray, CT)
- Billing Statement
- Outside records
- Other: _____

As required by the Health Insurance Portability and Accountability Act of 1996, MD West ONE PC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein.

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.

Printed Name: _____

Signature of Patient: _____ **Date:** _____

Signature of Parent/Legal Guardian: _____ **Date:** _____