

Lakeside Orthopedics, P.C.

MEDICAL RECORDS AUTHORIZATION FOR DISCLOSURE OF INFORMATION (PLEASE PRINT ALL INFORMATION)

Patient Name: _____

Date: _____

Date of Birth: _____

SS#: _____

Release Records From:

Release Records To:

Specific description of information to be release: Must identify the information in a specific and meaningful fashion:

_____ All Dates of Service

From _____ to _____

Purpose of releasing information: _____

Expiration Date: I understand that this authorization shall be in force and in effect until _____ (state the specific (1) expiration date or (2) event triggering the expiration) at which point the authorization will expire, Example: 30 days; until death, until litigation is closed.

Revocation of Authorization: I understand that I may revoke this authorization at any time by sending written notification to the providing organization at Lakeside Orthopedics, P.C., 16909 Lakeside Hills Ct. #208, Omaha, NE 68130. I understand that a revocation is not effective to the extent that, the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Conditioning of Authorization: I understand that the providing organization will not condition my treatment, payment, enrollment in health plan, or eligibility for benefits on my provision of an authorization for the requested use or disclosure unless my treatment is related to the research, my health care services are provided solely for the purposes of creating protected health information for disclosure to a third party, or if authorization is sought for the health plans eligibility or enrollment determination for underwriting purposes.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state privacy regulations.

Signature of Patient/Parent

Date: _____

Responsible Parties Signature (if not same as patient or parent)

Relationship to patient