New West Sports Medicine & Orthopaedic Surgery (New West)
2810 W 35th Street, Suite 1 - Kearney, NE 68845
Phone: (308) 865-2570 Fax: (308) 865-2508

Authorization to Disclose Health Information

Patient name: _____ **Date of birth:** _____ **Phone:** _____

Mailing address: _____

1. **I authorize New West to disclose the following (check one):**

   ☐ All my information maintained by New West Sports Medicine & Orthopaedic Surgery

   ☐ My information related to the following body part: _____

   ☐ My information for the following date(s): _____

   I understand that this information may contain information related to drug and alcohol abuse and treatment, HIV/AIDs, and/or psychological or psychiatric conditions, including psychotherapy notes.

2. **New West may disclose this information to:**

   Name and/or Organization: _____

   Mailing address: _____

   Fax number: _____ E-mail address: _____

3. **This authorization will remain valid (check one):**

   ☐ For one year from the date of the below signature

   ☐ Until the following date: _____

   ☐ Until the following event occurs: _____

   This authorization may be revoked at any time by notifying New West in writing. If the authorization is revoked, it would not affect any actions already taken by New West. Once New West discloses health information, the recipient may be able to disclose it as privacy laws may no longer protect it.

4. **Signature (if the patient is under 19, a parent or other legal representative must sign):**

   Signature of patient: _____ Date: _____

   Name of Parent or Legal Representative: _____

   Relationship to the patient: _____

   Signature of Parent or Legal Representative: _____ Date: _____