New West Sports Medicine & Orthopaedic Surgery

2810 West 35th Street
Kearney, NE 68845
Phone: (308) 865-2570 Fax: (308) 865-2508

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Phone Number(s): _____

☐ **Release To**: New West Sports Medicine 2810 W. 35th Street Kearney, NE 68845 Fax – (308) 865-2508 Name: _____ Address: _____ _____ Phone: _____ Fax: _____	☐ **Release From**: New West Sports Medicine 2810 W. 35th Street Kearney, NE 68845 Fax – (308) 865-2508 Name: _____ Address: _____ _____ Phone: _____ Fax: _____

1. Please specify the information to be disclosed (Please Check All That Apply):

☐ Medical Records (This Includes: Operative Reports, Diagnostic/Test Reports, and Clinical Documentation)

☐ Medical Images

☐ Billing

From (date):_____ to (date):_____

☐ Check here if you want this authorization to include future records for one year from the signature date.

I understand that this may include protected health information relating to AIDS (Acquired Immunodeficiency Syndrome), or HIV (Human Immunodeficiency Virus) infection, and/or psychiatric care, and/or treatment for alcohol and/or drug abuse.

2. This authorization may be revoked in writing at any time, but all action taken in reliance to the authorization before the time of revocation remains acceptable and valid. Unless otherwise revoked, this authorization will expire one year from the date it is signed.

3. All members of New West Sports Medicine & Orthopaedic Surgery are hereby released from any legal responsibility/liability for disclosure of the above information for the purposes indicated above.

Signature of Patient: _____ Date: _____
If the patient is under the age of 19, a parent or legal representative must sign

Signature of Legal Representative: _____Date: _____

Name of Legal Representative: _____

Relationship to Above Patient: _____