AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Foot and Ankle Center of Nebraska. to disclose my protected health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that my health information MAY INCLUDE information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse. I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I understand that I may revoke this authorization at any time by giving notice in writing at the address found below, but if I do it will not affect any actions taken before receipt of my revocation. I understand that limiting or revoking authorization to share medical information with your insurance provider may lead to denial of payment and I will be responsible for all unpaid charges.

I understand that my treatment will not be conditioned on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of treating protected health information for disclosure to a third party.

Persons/organizations to receive the information:

_____ Physicians & Medical Providers
_____ Hospitals & Medical Facilities
_____ Insurance Provider
_____ All Family
_____ Spouse
_____ Other _____

The specific information to be released/disclosed is specified below:

_____ Complete Medical Record
_____ Progress Notes
_____ X-Ray
_____ Operative reports
_____ Lab Reports
_____ Billing and Claim records
_____ Other _____
_____

Please exclude (Indicate by initialing): _____ HIV/AIDS information _____ Mental health _____ Drug / Alcohol treatment

This information is to be used/disclosed for the following purpose(s) only: _____
(No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)

If I request that all communications to be (by telephone, mail or otherwise) by the Foot and Ankle Center of Nebraska, P.C. and/or his staff are handled in the following manner:

- For oral communication: May we leave a message on your phone? _____ Yes _____ No
- For written communication: Send medical information to my home address: _____ Yes _____ No
  If no, send to the following address: _____

This authorization expires on January 1, 2017, unless you specify a different date_____.

Patient Name _____ Date of Birth _____

Signature of Patient or Representative _____ Date_____