AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Precision Foot & Ankle Center, P.C.
7828 Wakeley Plaza
Omaha, NE 68114
Ph: 402-926-2600 Fx:402-926-2605

Please provide **all** information requested or this Authorization is not valid.

Patient Name:_____**D.O.B.**_____

Address:_____

Telephone Number: (___)_____**SSN:**_____

I hereby authorize_____
(Facility or Provider Name and Location)

To release information from the medical record of_____
(Patient Name)

To:_____
(Name and Address of Person or Organization to which disclosure is to be made)

Fax # (____) _____ **Phone #** (____) _____

For treatment dates:_____

The following information: (Check all that apply)

- o Face sheet
- o H&P consultation
- o Progress notes
- o X-rays
- o Lab results
- o Operative report
- o Entire medical record

For the following purpose:

Legal

Insurance

Patient request

Other_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

This authorization will be valid for 180 days from the date it is signed or until_____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Precision Foot & Ankle Center cannot condition treatment or payment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

_____
(Legal Guardian's Relationship to Patient)