

New West Sports Medicine & Orthopaedic Surgery, P.C.
2810 W 35th
Kearney, NE 68845
(Telephone) 308-865-2570 (Fax)308-865-2508

Authorization to Disclose Health Information

Please Print

Patient Name: _____ **Date of Birth:** _____

Address: _____
street city state zip

Phone: _____
home cell

<p>Release To:</p> <p><input type="checkbox"/> New West Sports Medicine 2810 W 35th Kearney, NE 68845 Telephone # 308-865-2570 Fax # 308-865-2508</p> <p><input type="checkbox"/> _____ _____ _____ Telephone # _____ Fax # _____</p>	<p>Release From:</p> <p><input type="checkbox"/> New West Sports Medicine 2810 W 35th Kearney, NE 68845 Telephone # 308-865-2570 Fax # 308-865-2508</p> <p><input type="checkbox"/> _____ _____ _____ Telephone # _____ Fax # _____</p>
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What information to release:

- Medical Records Dates from _____ to _____
- X-rays of _____ MRI of _____

I understand that I may revoke this authorization by notifying this office in writing. If I do, it will not affect any actions already taken by this practice based upon this authorization. Once this office discloses health information, the person or organization receiving it may re-disclose it. Privacy laws no longer protect it. This authorization is good for one year from the date of signature.
I hereby release New West Sports Medicine & Orthopaedic Surgery, P.C. and its employees from any legal liability from the release of the above requested information.

- I will pick up Please mail

Signature: _____ **Date:** _____
(if the patient is under the age of 19 a parent must sign)

Signature of Legally Responsible Representative: _____

Relationship to above patient: _____

Office Use Only: Chart # _____
Faxed _____ Picked up _____ Mailed _____ Date: _____ Initials _____