

New West Sports Medicine & Orthopaedic Surgery, P.C.
3219 Central Avenue, Ste. 102
Kearney, NE 68847
(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

Release To:	Release From:
<input type="checkbox"/> New West Sports Medicine 3219 Central Avenue, Ste. 102 Kearney, NE 68847 Telephone # 308-865-2570 Fax # 308-865-2508	<input type="checkbox"/> New West Sports Medicine 3219 Central Avenue, Ste. 102 Kearney, NE 68847 Telephone # 308-865-2570 Fax # 308-865-2508
<input type="checkbox"/> _____ _____ _____ Telephone # _____ Fax # _____	<input type="checkbox"/> _____ _____ _____ Telephone # _____ Fax # _____

What information to release:

- Medical Records Dates from _____ to _____
- X-rays 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.

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 _____