AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Authorization. I, the undersigned, hereby authorize **CENTRAL NEBRASKA ORTHOPEDICS** (my "Provider") to use and/or disclose to _____ for the following purpose(s) (may state "per my request") _____ the following health information related to my care or treatment:

- ☐ History and physical examination
- ☐ Progress notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Consultation reports
- ☐ Doctor's office notes
- ☐ Entire medical record
- ☐ Emergency room records
- ☐ Discharge summary
- ☐ Discharge instructions
- ☐ Financial records
- ☐ Doctor's reports
- ☐ Physical therapy records
- ☐ Other_____

I specifically authorize the release of the following information related to testing, diagnosis, and/or treatment for (please initial applicable line): _____ HIV (AIDS virus), _____ sexually transmitted diseases, _____ mental health, or _____ drug and/or alcohol abuse.

Conditions, Further Uses and Disclosures. I understand that my Provider may not condition my right to receive health care or benefits on my signing this authorization. When my information is used or disclosed to other parties as instructed in this authorization, I understand that my Provider will not have the ability to monitor whether my health information may be further used or disclosed by such parties, and that my health information may no longer be protected by federal and state privacy laws.

Expiration. This authorization shall expire 180 days from the date of my signature unless I indicate an earlier date here: _____.

Revocation. I understand that I have the right to revoke this authorization at any time by providing my Provider with written notice, sent by certified mail or hand delivery to the attention of the Privacy Officer at the following address: _____.

By signing below, I acknowledge receipt of a signed copy of this authorization.

_____ Printed Name

_____ Date

_____ Signature

_____ Authority of Person Signing, if not Patient (*i.e.*, parent, legal guardian)

_____ Printed Name of Patient, if different than above