AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Foot and Ankle Center of Nebraska and Iowa 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, 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 my insurance provider means that I am responsible for all charges and will pay for services rendered at the time of my visits.*** I also acknowledge that I have been offered information on my rights by the Foot and Ankle Center of Nebraska and Iowa.

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:

_____ *All persons/entities listed*
_____ Physicians & Medical Providers
_____ Insurance Provider
_____ Spouse
_____ All Family
_____ 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)

Patient Name _____ Date of Birth _____

Signature of Patient or Representative _____ Date_____