

# Authorization to Disclose Health Information

Prairie Orthopaedic & Plastic Surgery, PC (POPS)  
Hurlbut/Machado/Krejci/Byington

Please print clearly

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Birth Date/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Phone

## Authorizes:

**Prairie Orthopaedic & Plastic Surgery, PC**  
4130 Pioneer Woods Drive, Suite #1  
Lincoln, NE 68505  
(p) 402.489.4700 (f) 402.489.5220

## Release of Protected Health Information To:

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Fax #

## Information To Be Released:

<input type="checkbox"/> Problem List	<input type="checkbox"/> Surgical/Operative Reports	<input type="checkbox"/> Immunizations
<input type="checkbox"/> Medication List	<input type="checkbox"/> Hospital Records including reports	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Allergy records	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Prescriptions
<input type="checkbox"/> Consultations	<input type="checkbox"/> Physical Therapy Notes	<input type="checkbox"/> Entire Record
<input type="checkbox"/> Office Notes		
<input type="checkbox"/> Other (Specify): _____		

**Dates:** From \_\_\_\_\_ To \_\_\_\_\_

## Purpose For Need Of Disclosure: (Check applicable categories)

<input type="checkbox"/> Further Medical Care	<input type="checkbox"/> Legal Investigation	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance Eligibility/Benefits	<input type="checkbox"/> Changing Physicians	
<input type="checkbox"/> Other (Specify): _____		

I understand that information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

## Your Rights With Respect To This Authorization:

**Right to Inspect or Copy the Health Information to be Used or Disclosed:** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form as provided in CFR 164.524. I may arrange to inspect my health information or obtain copies by contacting POPS.

**Right to Receive Copy of this Authorization:** I understand that if I agree to sign this authorization, which I am not required to do, I am entitled to a signed copy.

**Right to Refuse to Sign This Authorization:** I understand that I am under no obligation to sign this form and I need not sign this form in order to assure treatment at POPS.

**Right to Withdraw This Authorization:** I understand I have the right to revoke this authorization at any time and that written notification to POPS is required to do so. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that POPS has already made in reference to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**Expiration Date:** Unless otherwise revoked, this authorization will expire on the following date \_\_\_\_\_ or one (1) year from the date signed.

I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the POPS Privacy Officer at 402-489-4700.

**Signature of Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If signed by other than patient, state relationship and authority to do so.)

**Witness:** \_\_\_\_\_