



OrthoWest

Orthopedic & Sports Medicine
Specialists

PATIENT # _____

2727 S 144th Street, Suite 280 • Omaha, NE 68144 • 402-778-5200

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE RECORDS

1. _____
Patient Name Birthdate Maiden Name

2. AUTHORIZE:

3. RELEASE RECORDS TO:

4. INFORMATION TO BE RELEASED:

____ Progress Notes ____ Lab Reports ____ Surgery Reports
____ X-Ray Reports ____ X-Ray Films ____ Other (Specify) _____

5. PURPOSE FOR DISCLOSURE:

____ Further Medical Care ____ Payment of Insurance Claim
____ Application for Insurance ____ Disability Determination
____ Vocational Rehab Evaluation ____ Legal Investigation
____ Personal ____ Other _____

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period.

Specify Additional Time Period or "None"

7. I authorize release of my medical records in accordance with the specifications listed above. I understand written notification is necessary to cancel this request.

8. SIGNATURE OF PATIENT: _____ DATE: _____

(If signed by person other than patient, state relationship and authority to do so.)

RELATIONSHIP TO PATIENT: _____ WITNESS: _____

OrthoWest reserves the right to charge for the copying of medical records.