www.nebraskaspineandpain.com
E-mail: nscinfo@nebraskaspineandpain.com

Authorization for Release of Health Information from NSPC

Patient's name _____
Date of birth ____/____/____
Address _____
_____
_____
Telephone number (____) ____-_____

I hereby authorize Nebraska Spine + Pain Center to disclose my health information as follows:
Disclose to:
Name: _____
Address: _____
Phone: _____
Fax: _____

Purpose(s) of Disclosure: ☐ Continued Care ☐ Patient Use ☐ Disability/ FMLA ☐ Legal

Information to be disclosed:
☐ **All** records (office notes, hospital notes, lab test results, diagnostic tests and images, prior physician records)
☐ **Specific** records _____
☐ X-rays on CD
☐ Health information required to complete disability/FMLA paperwork.

Information protected by Federal and/or State law:
I understand that information in my health record may include information related to treatment for substance abuse, (including alcohol/drug abuse), mental health services, and HIV/AIDS related information (including test results). I authorize the release of this information unless ***specifically excluded*** as indicated below:

Exclusions: _____

Dates From: _____ to _____
(If no dates specified, all dates will be sent)

I understand and acknowledge that:
My refusal to sign this authorization will not affect my ability to obtain treatment at Nebraska Spine + Pain Center. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law. This authorization is effective until _____(specify date or event). If no date or event is specified, this authorization will expire twelve (12) months from the date of my signature. I understand that I may revoke this authorization at any time by giving written notice to Nebraska Spine + Pain. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

_____ _____
SIGNATURE: Patient/Personal Representative: I acknowledge that by typing my name, it shall constitute an effective original signature for all purposes under this document. Date

_____
Name of Personal Representative and Relationship to Patient

FOR NEBRASKA SPINE + PAIN CENTER USE:
Received by: _____(Employee/Dept)
MR #: _____ PHYSICIAN: _____

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.