Surgical Associates, PC

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Lincoln, Nebraska 68510
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Identification

Name:_____ Date of Birth_____
Address:_____ Phone:_____
City/State/Zip_____
Maiden/Previous Names/Nickname:_____

Provider (Who is releasing information?)

Provider/Facility Name:_____
Address:_____ Phone:_____
City/State/Zip _____

Disclose Information To? (Where is information to be sent?)

Name/Facility:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax: _____

Information to be Disclosed

__ Clinic Progress Notes
__ Physician's
__ Nurse's
__Hospital Progress Notes
___ Physicians
___ Nurse's
___Other Progress Notes
____ Education Information
____ ER Records
____ Discharge Summary
____ Psychiatric Evaluation
____ Psychological
____ Psychosocial Assessment
___Assessment for Drug or Alcohol Dependency
_Radiology
_EKG/Cardiology
_Consultation Reports
_Outpatient Information
__Immunization Record
___Allrecords
___ Lab Data
__ Pathology
___Operative
___ H&P

Service Dates

Time period from: _____ to: _____
Concerning:_____
(specific diagnosis or treatment, auto accident, etc.)

Purpose of Disclosure

__Continuing Medical Care
___Insurance Claim
___Other (Specify)_____
___Consult/Second opinion
___Legal
___ Out of town move
__ Personal

For marketing: The disclosing organization__will__will not receive compensation, monetary or otherwise, as a result of this use or disclosure.

Expiration Date

This authorization will expire one year from the date of signature or on _____

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken In reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining Insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning tile above named patient to the party Identified In the section entitled "Disclose Information To", I understand that the information to be released may include Information regarding mental health, alcohol and drug abuse, and HIV-related Information. I understand that once the information is disclosed, it may be subject to re-disclosure by the receipt and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of patient/representative Signature Date

_____ _____
Relationship to patient, if signed by representative Witness -optional

Please supply proof of authority to act for minors, proof only required if other than parent.