

HEALTHSERVICESONE, P.C.,
 DBA KEARNEY ORTHOPEDIC & SPORTS MEDICINE/FIRST SURGICENTER
 3500 CENTRAL AVE., PO Box 2168, KEARNEY, NE 68848
 PHONE 308-865-2500 FAX 308-865-1459

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ D.O.B. _____

ADDRESS _____ PHONE # _____ ACCT. # _____

I hereby authorize HealthServicesOne, P.C. (HSO) dba Kearney Orthopedic & Sports Medicine/First SurgiCenter to: disclose to obtain from

Organization: _____

Address: _____

City, State, Zip: _____

Fax #: _____

PURPOSE(S) OF DISCLOSURE: _____

INFORMATION TO BE DISCLOSED : DATES OF SERVICE/TIME PERIOD _____
 (State time period or "all")

<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> X-Ray Films
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Financial Records
<input type="checkbox"/> Diagnostic Test Results	<input type="checkbox"/> Other (please describe)
<input type="checkbox"/> X-Ray Reports	

I understand and acknowledge that:

1. The 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.
2. My refusal to sign this authorization will not affect my ability to obtain treatment at HSO.
3. 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.
4. This authorization is effective for six months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the Medical Records Specialist. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
5. I have read (or had read to me) and have received a copy of this document.

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

 Signature of patient or patient's personal representative

 Relationship to patient if signed by personal representative

 Date

FOR OFFICE USE ONLY:	
_____ Staff Disclosing Information	
_____ Date Disclosed	
<input type="checkbox"/> Fax	<input type="checkbox"/> Mailed <input type="checkbox"/> Picked up