

# MEDICAL RECORDS RELEASE



6345 S. 56th Street Suite 100  
Lincoln NE 68516  
402.420.0020 fax 420.420.0014

I authorize Center for Spine and Sport Rehab to use and/or disclose a copy of the specific health and medical information identified for:

*(name of patient)*

to: *(name)*

*(address of recipient)*

for the following purposes: *(describe each purpose of use/disclosure)*

List the information that is to be used:

I understand that if the person or entity receiving the information is not a health care provider of health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations. However, the recipient may be prohibited substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

[If applicable] I also understand that the person I authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance upon this authorization. Submit the revocation of authorization to the clinic that you made the original request.

This authorization expires *(applicable date or event)*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Personal Representative(if applicable)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Clinic Representative/Witness

\_\_\_\_\_  
Date

**A copy of this signed form is to be provided to the patient.**