Neurological and Spinal Surgery, L.L.C.

A team approach to neurosurgical and spinal care

Authorization to Receive Medical Information

Printed Legal Name of Patient _____ Date of Birth _____

Patient Address _____ Daytime Phone Number _____

I authorize _____ to release the following Information to:

Neurological and Spinal Surgery, LLC
Bryan LGH West Medical Plaza
Suite 305 Tower B
Lincoln, NE 68502
Fax: 402-483-8781

Dates of information to be disclosed: ____/____/____ to ____/____/____ Or ☐ Most Recent

- ☐ Procedure Notes
- ☐ Operative Notes
- ☐ History and Physical
- ☐ Consultation Reports
- ☐ Physician Clinic Notes
- ☐ Laboratory Reports
- ☐ Radiology reports

Reason for disclosure: _____

- I understand that Neurological and Spinal Surgery, LLC will disclose only information completed or ordered by their clinical staff. Any outside information or Independent reviews must be requested from said facility or responsible party.
- I understand that once my information is disclosed, the information is subject to re-disclosure and may no longer be protected by the HIPAA Privacy Rule or other applicable law.
- Unless otherwise revoked, authorization will expire one year from the date signed.

Signature of Patient or Legal Representative _____ Date _____

If Signed by Personal Representative, Relationship to Patient _____

For Office Use Only:

Prepared By: _____ Date: _____

Disclosed By: _____ Date: _____