Neurological and Spinal Surgery, L.L.C.

A team approach to neurosurgical and spinal care

Authorization for Release of Medical Information

Photo ID required to receive records

_____ _____

Printed Legal Name of Patient Date of Birth

_____ _____

Patients Address Daytime Phone Number

I authorize **Neurological and Spinal Surgery, LLC** to release the following Information to: _____

Recipient Fax Number

_____

Street Address City / State / Zip Phone Number

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

- Í Procedure Notes
- Í Operative Reports
- Í History and Physical
- Í Consultation Reports
- Í 3T MRI CD CHI STE ONLY
- Í Physician Clinic Notes
- Í Laboratory Reports
- Í Radiology reports
- Í Correspondence

- ⬭ Paper Copy
- ⬭ CD- pdf format
- ⬭ Patient Portal

*For a CD of imaging completed at NSS patients need to contact AMI 484-6677.

Reason for disclosure: _____

- I understand that Neurological and Spinal Surgery, LLC will disclose only information completed or ordered by their clinical staff only. Any outside information or Independent reviews must be requested from said facility or responsible party. Please allow 7-10 business days for processing of all requests
- Under Nebraska statute 71-8404 & HITECH -I understand that a fee will be attached to obtain a copy of the requested records. The fees are as follows: $.50 per page for paper copies. CD is $6.50 . **Full payment is required before records will be released. No Charge for records to be sent to the Patient Portal.
- 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: _____

Pages Disclosed: _____ Charge $ _____ Payment Method:_____

Please Return to: Neurological and Spinal Surgery LLC
Fax: 402-483-8709 ATTN : April

Mail : 2222 S 16th St, Ste 305 Tower B
Lincoln, NE 68502