



Nebraska Orthopaedic

ASSOCIATES

Orthopaedics • Sports Medicine • Joint & Hand Specialists

Consent for Sharing of Protected Health Data and Information

*** This form does not authorize the release of medical records***

1. Please list the names and relationship of family members or other persons, if any, whom we may inform verbally about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

- | | |
|-------------------------------|-------------------------------|
| 1. _____
Name/relationship | 3. _____
Name/relationship |
| 2. _____
Name/relationship | 4. _____
Name/relationship |

2. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address.

3. Please print the telephone numbers where you want to receive calls about your appointments, lab and test results, or other health care information.

- HOME _____
- WORK _____
- CELL PHONE* _____
- OTHER PHONE _____

** I am fully aware that a cell phone is not a secure and private line*

4. Can confidential messages (i.e. appointment reminders, test results, etc.) be on your telephone answering machine or voicemail?

YES _____ NO _____

PATIENT NAME _____

CHART NUMBER _____ AGE IF MINOR _____

X _____ Date of signing _____
Signature of Patient

X _____ Date of signing _____
Signature of Patient's Representative/Guardian

Representative's Relationship to Patient

X _____
Witness Signature (Office Representative)

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