PATIENT CONSENT AND AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Authorization for Use/Disclosure of Information: I, _____, of
(Patient Name)

_____, born _____,
(Patient Address) (Date of Birth)

hereby authorize and direct

Miracle Hills Surgery Center
11819 Miracle Hills Dr. Ste 201
Omaha, NE 68154

to furnish to

Name: _____

Address: _____

Fax: _____

the following medical records and information

_____
(Specify patient name, admission date, or period concerned)

This information is released for the following purpose:

_____

("At the request of the patient" is sufficient if patient is requesting the information)

Term: I understand this authorization will remain in effect:

- From the date of this authorization until the _____ day of _____, 20_____.
- Until the provider fulfills the request.

_____ _____
(Signature of Patient) (Date of Consent)

_____ _____
(Signature of Legally Responsible Party) (Date of Consent)

_____
(Specify Relationship to Patient)

_____ _____
(Witness Name) (Date)

_____
(Signature of Witness)