Medical Records
How to Obtain Your Clinic Medical Records

If you would like to personally pick up your records
*Specify on your request that you would like to pick up your records
*Be sure to provide a contact phone number where we can reach you
*If records are needed by a specific date, please specify that on your request
*A valid driver's license or other form of picture identification is required to pick up copies of your records.

Foot and Ankle Specialists will be glad to offer one (1) copy of your Medical Records *free of charge*.
However there may be a charge for your records if you require additional copies
The fees are as follow:

Additional copies of Medical Records CD Image of X-rays:
$20.00 Process Fee of Medical Records, +.20 cents per page copy fee +postage (if applicable)
$10.00 per CD Copied

Payment has to be made prior to release of records. Please keep your records for yourself and if needed make copies to take to another provider.

****There is no charge for records if our doctor refers you on for continuation of care******

How long should the process take?
*In most cases record copies are available in less than a week.
*Some requests take longer to process. If you have questions you may contact Medical Records Department 402-331-6387 to verify the status of your request

****Please note that it is the Policy of **Foot and Ankle Specialist** to only release information created by this office and not re-disclose information created elsewhere.

FOOT & ANKLE SPECIALISTS

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2705 Samson Way **18010 R Plaza, Suite 106** **1301 N. 72nd Street**
Bellevue, Ne 68123 **Omaha, Ne 68127** **Omaha, Ne 68114**
402-991-8999 **402-331-6537 fax**

AUTHORIZATION FOR DISCLOSURE of PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____City /State/ Zip_____

Contact Phone #: (_____)_____ Previous Name (if applicable): _____

I hereby authorize FOOT & ANKLE SPECIALISTS
To ***REQUEST*** information for the medical record of: _____
(PATIENT NAME)

FROM:
Name of Doctor or Facility: _____
Address: _____City / Zip _____
Phone_____ Fax_____

I hereby authorize FOOT & ANKLE SPECIALISTS
To ***RELEASE*** information from the medical record of: _____
(PATIENT NAME)

To: __Self __Doctor __Facility __Other: _____

Name: _____

Address: _____City /State/ Zip_____

Phone_____ Fax_____

For The Reason of: __Personal File __File Disability/FMLA
__Other/ Reason: _____

Delivery Method: ___Mail to the above ___Will Pick Up when ready: ID Check Required
Preferred Location: __Bellevue __180th & Q ___72nd St

Specific Date Records Needed By: _____
* Please Allow Minimum of 72hrs to Process Your Request *In most cases, copies are available in less than 72hrs.*Some requests may take longer to process.

The Following Information Requested: (Check all that apply)

____ Doctor Dictated Progress/Visit Notes
____ Physical Therapy Dictated Progress/Visit Notes
____ Digital Copy X-ray (CD cannot be faxed)
____ Other: _____

Please note, items will not be faxed if file is more than 25 pages

Special Limitation to EXCLUDE the following protected information from this authorization:

____ HIV/AIDS related testing

____ Mental Health

____ Chemical Dependency (Drug/Alcohol)

This authorization may be revoked at any time by notifying FOOT & ANKLE SPECIALISTS in writing. This Authorization will remain in effect for 120days.

_____ _____
Signature of Patient, or Legal Guardian (Parent or Guardian must sign if patient is minor) **DATE**

01/01/2015 *Prepared by Staff: _____* *ID Check By Staff: _____*