METHODIST
HEALTH SYSTEM

METHODIST HOSPITAL
METHODIST WOMEN'S HOSPITAL
METHODIST JENNIE EDMUNDSON HOSPITAL
METHODIST PHYSICIANS CLINIC

Patient Authorization for Disclosure of Health Information

Patient Name: ______________________ Date of Birth: ____________

Address: ______________________ City: ____________ State: ______ Zip: ______

Phone: ______________________ Previous/Maiden Name: ______________________

I request that Nebraska Methodist Health System (NMHS) or an affiliate ☐ release information to or ☐ obtain from the facility below:

Recipient of my information Name: ______________________

Address: ______________________ City: ____________ State: ______ Zip: ______

Phone: ______________________ Fax (healthcare provider only): ______________________

For Employees Only: ☐ Access to all NMHS electronic health records by Employed Family Member (view only)

Records Released From:

☐ *Hospital* ☐ *Clinic* ☐ *Both*

The information to be disclosed relates to date(s) of care/treatment: ____________ **OR Date Range: To** ________ **From** ________

☐ Emergency Room Record	☐ Laboratory Reports	☐ Physician Office Visits
☐ Complete Medical Record	☐ Radiology Reports	☐ Medication List
☐ Operative Report(s)	☐ Radiology Images	☐ PT/OT
☐ Abstract (discharge summary, history and physical, operative report(s), consultations and test results)	☐ Immunization Record	☐ Other:
☐ All encounters/visits at Dr: ______________________		

The purpose of the disclosure:

☐ Request of Individual/personal	☐ Change of Doctor/Transfer of Care	☐ Legal
☐ Referral to Specialist	☐ Insurance –type:	☐ Other
☐ Continuing Care	☐ Workers Comp	

Disclosure Format (Paper is default) ☐ Mail ☐ Fax ☐ E-mail (complete portal release) ☐ Electronic format *(CD default)*

I understand that the information in my health record may include information relating to alcohol, drug, or substance abuse, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or gene related impairments including genetic testing. You are authorized to release all information related to such diagnosis, testing and treatment unless specifically excluded as set forth below:

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By signing this Authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at 8303 Dodge St. Omaha, NE 68114. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire one (1) year from the date signed below or upon the following date/event/condition: ______________________.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

______________________ ______________________
Patient or Authorized Representative Signature Printed Name

______________________ ______________________
Date Relationship to patient is applicable

If applicable, please attach legal documentation if required, i.e. Power of Attorney, guardianship, personal representative

Contact Information:

Methodist Physicians Clinic Release of Information
10060 Regency Cir.
Omaha, NE 68114
Ph# 402-354-1494
Fax# 402-354-1350
roi@nmhs.org
Hours of Operation Monday – Friday 8am-5pm
Closed noon-1:00pm

Nebraska Methodist Hospital
8303 Dodge St.
Omaha, NE 68114
Ph# 402-354-1460
Fax# 402-815-9163
nmhs.hospitalroi@nmhs.org
Hours of Operation Monday – Friday 8am-5pm

Methodist Jennie Edmundson
933 E. Pierce St.
Council Bluffs, IA
Ph# 402-354-1460
Fax# 402-815-9163
nmhs.hospitalroi@nmhs.org
Hours of Operation Monday – Friday 8am-4pm

For Office Use Only

Date Rcd: ____________________

Location: ____________________

MRN: ____________________

Pg. Count: ____________________

FIN#: ____________________

Released By: ____________________

Printed By: ____________________

Released Dt: ____________________

ID: ____________________