

Patient Authorization for Disclosure of Health Information



ALL AFFILIATES OF METHODIST HEALTH SYSTEM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Previous/Maiden Name: \_\_\_\_\_

I authorize an affiliate of Nebraska Methodist Health System (NMHS) to [ ] Release information to; or [ ] Obtain information from:

Sender Name: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Recipient Name: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Disclosure Format: [ ] Paper [ ] Electronic [ ] CD [ ] Patient Portal

Delivery method for records: [ ] Pick-up [ ] Mail [ ] Fax [ ] Encrypted Email

Date range of information to be disclosed or obtained: From \_\_\_\_\_ (date) to \_\_\_\_\_ (date).

I request the following information to be released to or to be obtained:

- [ ] Entire Medical Record (including Substance Use Disorder records)
[ ] Diagnostics
[ ] Emergency Department Records
[ ] Operative Report(s)
[ ] Mental and/or Behavioral Health Records (excluding psychotherapy notes)
[ ] Radiology: [ ] Reports [ ] Images
[ ] Home Health and Hospice
[ ] All encounters/visits with Dr: \_\_\_\_\_
[ ] Other: \_\_\_\_\_
[ ] For Employees Only: Access to all NMHS health records by employed family member named above
[ ] History and Physical Exam
[ ] Laboratory/Pathology Reports
[ ] Immunization Records
[ ] Doctors Office/Clinic Records
[ ] Substance Use Disorder Records
[ ] All substance use disorder information
[ ] Only some of my substance use disorder information: (please specify) \_\_\_\_\_
[ ] Discharge Summary
[ ] Clinical Progress Notes
[ ] Medication List
[ ] Physical/Occupational Therapy
[ ] Abstract (discharge summary, history and physical, operative reports, consultations and test results)
[ ] Dunklau Gardens Nursing Home

The purpose of releasing or obtaining the above information is:

- [ ] Insurance/Billing [ ] Legal [ ] Other: \_\_\_\_\_
[ ] Continuing/Transferring/Referral of Medical Care or Treatment
[ ] Request of Patient, Parent, or Other Authorized Representative

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, except where an affiliate of NMHS has already acted in reliance on your authorization. Revocation must be made in writing to the health information management department of the releasing entity. Addresses can be found on page 2 (on the back) of this form.
• 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.

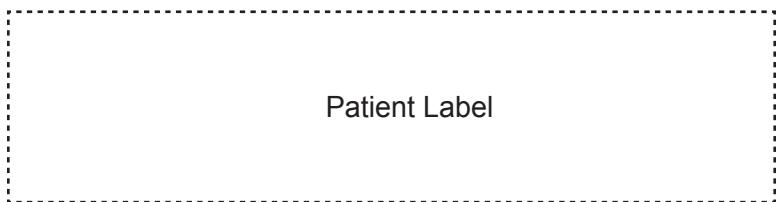
Prohibition on Re-Disclosure of Substance Use Disorder Records: Substance Use Disorder records are protected by Federal law. 42 CFR Part 2 prohibits unauthorized disclosure of these records. 42 CFR Part 2 prohibits NMHS from making any further disclosure of information in your record that identifies a patient as having or having had a substance use disorder without specific written authorization of the patient or the patient's representative, or as otherwise permitted by law.

\_\_\_\_\_  
Patient or Authorized Representative Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if applicable)



Patient Label

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

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

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 Fremont Health  
Health Information Management  
450 E 23rd St  
Fremont, NE 68025  
Ph# 402-727-3434  
Fax# 402-727-3514  
Hours of Operation: Monday - Friday 8am - 4:30pm

Methodist Women’s Hospital  
Health Information Management  
707 N. 190<sup>th</sup> Plaza  
Omaha, NE 68022  
Ph# 402-354-1460  
Fax# 402-815-9163  
nmhs.hospitalroi@nmhs.org  
Hours of Operation: Monday – Friday 8am-4pm

For Office Use Only:

Date Received: \_\_\_\_\_ Location: \_\_\_\_\_

MRN: \_\_\_\_\_ Pg. Count: \_\_\_\_\_

FIN#: \_\_\_\_\_ Released By: \_\_\_\_\_

Printed By: \_\_\_\_\_ Released Date: \_\_\_\_\_

ID: \_\_\_\_\_