

Patient Authorization for Disclosure of Health Information



ALL AFFILIATES OF METHODIST HEALTH SYSTEM

(1) Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Previous/Maiden Name: _____

I authorize the following affiliate of Nebraska Methodist Health System (NMHS) to release/obtain records: Methodist Physicians Clinic
 Methodist Hospital Methodist Women's Hospital Methodist Jennie Edmundson Hospital Methodist Fremont Health

(2) INFORMATION TO BE RELEASE TO:
INDICATE EACH SPECIFIC CLINIC OR PROVIDER

ORGANIZATION, DOCTOR OR NAME _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ FAX _____

(3) INFORMATION TO BE RELEASE FROM:
REQUEST MUST HAVE COMPLETE ADDRESS

ORGANIZATION, DOCTOR OR NAME _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____ FAX _____

(4) Disclosure Format: CD Electronic Paper
(5) Delivery method for records: Fax Mail Pick-up Patient Portal Encrypted Email _____
(6) Date range of information to be disclosed or obtained: From _____ (date) to _____ (date).
(7) I request the following information to be released or to be obtained:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abstract (discharge summary, history and physical, operative reports, consultations and test results) | <input type="checkbox"/> Emergency Department Records | <input type="checkbox"/> Operative Report(s) |
| <input type="checkbox"/> Diagnostics | <input type="checkbox"/> Employee Health | <input type="checkbox"/> Physical/Occupational Therapy |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Radiology: <input type="checkbox"/> Reports <input type="checkbox"/> Images |
| <input type="checkbox"/> Doctors Office/Clinic Records - Dr. _____ | <input type="checkbox"/> Home Health and Hospice | <input type="checkbox"/> Substance Use Disorder Records |
| <input type="checkbox"/> Dunklau Gardens Nursing Home | <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> All substance use disorder information |
| | <input type="checkbox"/> Mental and/or Behavioural | <input type="checkbox"/> Only some of my substance use disorder information: (please specify): _____ |
| | <input type="checkbox"/> Health Records (excluding psychotherapy notes) | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> Entire Record (including Substance Use Disorder records) |

For Employees Only: Access to all NMHS health records by employed family member named above

(8) The purpose of releasing or obtaining the above information is:
 Continuing/Transferring/Referral of Legal Other: _____
 Medical Care or Treatment Request of Patient, Parent, or Other
 Insurance/Billing Authorized Representative

(9) 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 my 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.
• Unless otherwise revoked, this authorization will expire one (1) year from the date signed below or upon the following date/event/ by federal confidentiality rules.
• Information disclosed may contain information about alcohol/drug abuse, sexually transmitted diseases, AIDS, HIV, genetics, or self-paid services.

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

Date

Printed Name

Relationship to Patient (if applicable)



Contact Information:

Methodist Health System
Release of Information
10060 Regency Cir.
Omaha, NE 68114
NMHS.ROI@NMHS.org
Hours of Operation: Monday – Friday 8am-5pm

Phone# 402-354-4660
Fax# 402-354-1350

All entities of Methodist Health System

Methodist Fremont Health
Methodist Jennie Edmundson
Nebraska Methodist Hospital
Methodist Physicians Clinic
Methodist Women’s Hospital

For Office Use Only:	<input type="checkbox"/> MFH	<input type="checkbox"/> MH	<input type="checkbox"/> WH	<input type="checkbox"/> JE	<input type="checkbox"/> MPC	<input type="checkbox"/> HIM to complete
MRN: _____	Pg. Count: _____					
FIN#: _____	Released By: _____					
Printed By: _____	Released Date: _____					
<input type="checkbox"/> NE Drivers License	<input type="checkbox"/> IA Drivers License	<input type="checkbox"/> Patient ID Band				
<input type="checkbox"/> Work ID Badge	<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Other _____				