AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Allow At Least 5 Working Days For Records To Be Prepared. There May Be A Charge For This Service.

Patient Name _____**Date of Birth**_____

Address_____

Day time Phone Number or number where we can reach you ( ) _____

1. REQUEST RECORDS FROM

☐ Regional West Medical Center, 4021 Ave B Scottsbluff, NE 69361

☐ Other _____

2. RELEASE RECORDS TO ☐ Regional West Medical Center, 4021 Ave B Scottsbluff, NE 69361

☐ Patient at the same address as above ☐ By Mail or ☐ For Pick-up

☐ Other (include name, address, phone#)_____

_____

3. Purpose ☐ At the request of the Patient ☐ Continued Care ☐ Attorney ☐ Finance

☐ Other_____

Covering the dates(s) of service From _____**To**_____

4. I would like the following information released

___History and Physical	___Discharge Summary	___Operative Notes	___Progress Notes	___Radiology Reports
___Emergency Report	___Dismissal Instructions	___Social History	___Physical Therapy	___Radiology Images
___Cardiology	___Psychological Evaluations	___Consultation	___Lab	___Other _____

5. Medical Record to be release as ☐ Paper or ☐ CD

Radiology images will be released on a separate CD

6. Without my express revocation, this authorization will expire in 180 days from date of signature. A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient

I understand that if the information in my health record includes information relating to behavioral or mental health services, treatment for alcohol and / or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), I agree to its release.

Check one ☐Yes ☐No

A. Authorization, I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken to comply with it.

B. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form.

C. Re-Disclosure, I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

7. **SIGNATURE** Patient_____Date_____

8. If other than the patient, indicate relationship ___Parent ___Guardian / Legal Representative/POA (circle one)

Identity of Patient and / or Signature Verified via ___Photo ID ___Matching Signature ___Other_____

Verified by_____Date_____

Office Use Only This request was completed by _____Date_____# _____