

Mary Lanning Healthcare –Health Information Management (HIM)

Mailing Address: 715 N. St. Joseph Ave. **Fax Number:** 402-461-5311
Hastings, NE 68901

1. Patient Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
_____ SSN #: _____
(optional or last 4 digits)

2. I hereby authorize and request release of my medical records

From:

Healthcare facility to send information: _____

To:

Name of organization or individual to receive information: _____

Street Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

3. **Information to be disclosed:** From (date): _____ To (date): _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Financial Record | <input type="checkbox"/> Psychiatric Information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Radiology Films |
| <input type="checkbox"/> Echo Cardiogram | <input type="checkbox"/> Lab | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> EKG | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> Facesheet | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Other (Specify): _____ |

Disclosure Format (paper is default):

- CD Encrypted email *Unencrypted email Fax #: _____

**Note: If selecting Unencrypted email, I understand the risk in receiving my PHI this way and that it may be read by a third party.*

**Fees: I understand that there may be a fee charged for the copying of medical records.*

4. **Purpose of Disclosure:**

- Insurance / Payers Legal Proceedings Personal Treatment
 Other (specify) _____

5. I understand that the information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that a revocation will be made in writing and will not apply to information that has already been released in response to his authorization. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless previously revoked, this authorization will expire one year from date of signature or _____.
I consider a photocopy of this authorization to be as valid as the original. My refusal to sign this authorization will not affect my ability to obtain treatment at Mary Lanning Healthcare. I understand that I may inspect or have copied the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal privacy rules.

Signature of Patient

Signature of Legal Representative

Date

Relationship of above person to patient



Authorization to Use and Disclose Protected Health Information

HIM-125

Created: 06/08
Revised: 05/10, 11/10, 11/12, 12/13, 03/14, 10/14, 12/14, 05/15, 09/18, 01/20