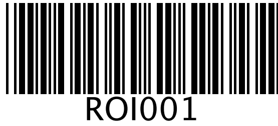
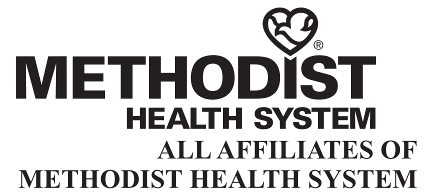
Document Type: Request for ROI
Subject: Request for ROI



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 RELEASED *TO*:
INDICATE EACH SPECIFIC CLINIC OR PROVIDER

____
ORGANIZATION, DOCTOR OR NAME

____
STREET ADDRESS

____
CITY, STATE, ZIP

____
PHONE FAX

(3) INFORMATION TO BE OBTAINED *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: ☐ Encrypted Email ☐ Fax ☐ Mail ☐ Pick-up ☐ Patient Portal
(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:

☐ Abstract (discharge summary, history and physical, operative reports, consultations and test results)
☐ Diagnostics
☐ Discharge Summary
☐ Doctors Office/Clinic Records - Dr. ______________________
☐ Dunklau Gardens Nursing Home
☐ Emergency Department Records
☐ Employee Health
☐ History and Physical Exam
☐ Home Health and Hospice
☐ Laboratory/Pathology Reports
☐ Mental and/or Behavioral Health Records (excluding psychotherapy notes)
☐ Operative Report(s)
☐ Physical/Occupational Therapy
☐ Radiology: ☐ Reports ☐ Images
☐ Substance Use Disorder Records
  ☐ All substance use disorder information
  ☐ Only some of my substance use disorder information: (please specify): ______________________
☐ Other: ______________________
☐ 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 Medical Care or Treatment
☐ Insurance/Billing
☐ Legal
☐ Request of Patient, Parent, or Other Authorized Representative
Other: ______________________

(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.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected 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

____
Printed Name

____
Date

____
Relationship to Patient (if applicable)

METHODIST HEALTH SYSTEM

ALL AFFILIATES OF METHODIST HEALTH SYSTEM

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
Health Information Management
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. 190th Plaza
Omaha, NE 68022
Ph# 402-354-1460
Fax# 402-815-9163
nmhs.hospitalroi@nmhs.org
Hours of Operation: Monday – Friday 8am-4:30pm

For Office Use Only: ☐ HIM to complete

Date Received:____________ Location:____________

MRN:____________ Pg. Count: ____________

FIN#:____________ Released By: ____________

Printed By:____________ Released Date: ____________

ID: ____________