Fremont Health

1.3.304

AUTHORIZATION FOR RELEASE/REVIEW OF HEALTH INFORMATION

PATIENT NAME_____DOB_____

ADDRESS_____PHONE #_____

CITY_____STATE_____ZIP_____ACCT #_____

Please indicate where records are being disclosed from:

___Fremont Health Medical Center ___All Clinic Records ___ Internal Medicine ___ Family Care ___Healthcare for Women ___Orthopaedics

___Surgical Group ___ Infectious Disease ___Lake Wanahoo ___West Shores ___Other_____

RECORDS RELEASED VIA: ___Paper Copies ___CD ___E-mail

This disclosure is being made at the request of the individual.

☐ DISCLOSURE OF HEALTH INFORMATION: I hereby authorize Fremont Health to use and/or disclose my health information to the following:

_____

Facility/Individual Name Address Fax/Phone #

☐ REQUEST FOR HEALTH INFORMATION: I hereby authorize the following to use and/or disclose my health information to Fremont Health:

_____

Facility/Individual Name Address Fax/Phone #

PURPOSE OF DISCLOSURE/REQUEST:_____

INFORMATION TO BE DISCLOSED:_____

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED:_____

(State time period or "all")

___All Records ___Discharge Summary ___History and Physical Examination ___Consultation Report/Notes ___Pathology & Operative Report

___Emergency Room Record ___Lab Reports ___X-Ray Reports ___Complete Record ___Financial Record ___History ___Progress Notes ___Physical Exam

___Problem/Medication List ___Immunization Records ___Other_____

I specifically authorize the release of information related to:

___Substance Abuse (including alcohol/drug abuse) ___Child Abuse/Adoption

___HIV/AIDS related information (including test results) ___Mental Health

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Fremont Health.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. This authorization is effective for 6 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the Fremont Health - Health Information Department. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____

Signature of Patient or Patient's Personal Representative Date

_____

Relationship to Patient if Signed by Personal Representative (statement of authority should be provided)

Fremont Health Release of information Department 450 E. 23rd Street, Fremont, NE 68025 Office: 402.727.3323 Fax: 402.727.3514