# Patient Authorization for Disclosure of Health Information

METHODIST HEALTH SYSTEM

**ALL AFFILIATES OF METHODIST HEALTH SYSTEM**

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

I authorize an affiliate of Nebraska Methodist Health System (NMHS) to ☑ Release information to; or ☐ Obtain information from:

Sender Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

Recipient Name: GeneMatters
Address: 1015 Glenwood Ave City: Minneapolis State: MN Zip: 55405
Phone: 1-866-741-5331 Fax: _____ Email: _____

Disclosure Format: ☐ Paper ☑ Electronic ☐ CD ☐ Patient Portal
Delivery method for records: ☐ Pick-up ☐ Mail ☐ Fax ☐ Encrypted Email
Date range of information to be disclosed or obtained: From _____ (date) to _____ (date).

I request the following information to be released to or to be obtained:

- ☑ Entire Medical Record (including Substance Use Disorder records)
- ☐ Diagnostics
- ☐ Emergency Department Records
- ☐ Operative Report(s)
- ☐ Mental and/or Behavioral Health Records (excluding psychotherapy notes)
- ☐ Radiology: ☐ Reports ☐ Images
- ☐ Home Health and Hospice
- ☐ All encounters/visits with Dr: _____
- ☐ History and Physical Exam
- ☐ Laboratory/Pathology Reports
- ☐ Immunization Records
- ☐ Doctors Office/Clinic Records
- ☐ Substance Use Disorder Records
  - ☐ All substance use disorder information
  - ☐ Only some of my substance use disorder information: (please specify) _____
- ☐ Discharge Summary
- ☐ Clinical Progress Notes
- ☐ Medication List
- ☐ Physical/Occupational Therapy
- ☐ Abstract (discharge summary, history and physical, operative reports, consultations and test results)
- ☐ Dunklau Gardens Nursing Home
- ☐ Other: _____
- ☐ For Employees Only: Access to all NMHS health records by employed family member named above

The purpose of releasing or obtaining the above information is:

- ☐ Insurance/Billing
- ☐ Continuing/Transferring/Referral of Medical Care or Treatment
- ☐ Legal
- ☐ Request of Patient, Parent, or Other Authorized Representative
- ☒ Other: Genetic Counseling Referral

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 your 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.

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)

Patient Label

**PERMANENT PART OF MEDICAL RECORD**



**RELEASEOFINFO**
**Rev 01/2019**

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

Nebraska Methodist Hospital
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 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-4pm

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

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

For Office Use Only:

Date Received: _____ Location: _____

MRN: _____ Pg. Count: _____

FIN#: _____ Released By: _____

Printed By: _____ Released Date: _____

ID: _____