METHODIST HEALTH SYSTEM
ALL AFFILIATES OF METHODIST HEALTH SYSTEM

Patient Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Previous/Maiden Name: _____

I authorize the disclosure/release of my information (Request must have complete addresses):

To: Name _____
Address_____
City/State/Zip_____
Phone/Fax_____/_____

From: Name_____
Address_____
City/State/Zip_____
Phone/Fax_____/_____

☐ **Above is an NMHS Employee:** Access to all NMHS health records by employed family member named above

Information to be disclosed/released: Date(s) of service requested: From _____ (date) to _____ (date).

- ☐ Abstract (discharge summary, history and physical, operative reports, consultations and test results)
- ☐ Entire Medical Record
- ☐ Discharge Summary
- ☐ Laboratory/Pathology Reports
- ☐ Other: _____
- ☐ Radiology: ☐ Reports ☐ Images
- ☐ Medication List
- ☐ Immunization Records
- ☐ Emergency Department Records
- ☐ Physical/Occupational Therapy
- ☐ Employee Health
- ☐ Mental and/or Behavioral Health Records (excluding psychotherapy notes)
- ☐ Substance Use Disorder Records
  - ☐ All substance use disorder information
  - ☐ Only the following substance use disorder information: _____

The purpose of releasing or obtaining the above information is:
☐ Continuity of Care ☐ Insurance/Billing ☐ Legal ☐ Personal ☐ Other:_____

Disclosure Format and Delivery Method:
☐ Electronic via Encrypted Email: _____
☐ CD and/or ☐ Paper ☐ Other:_____
☐ Please Mail OR ☐ I will pick up at Methodist Physicians Clinic Regency

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.
- Information disclosed may contain information about alcohol/drug abuse, sexually transmitted diseases, AIDS, HIV, 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. Upon my request, I have the right to receive a list of entities that have received my substance use disorder information.

_____ _____
Patient or Authorized Representative Signature Printed Name

_____ _____
Date Relationship to Patient (if applicable)

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Please allow a minimum of 72 hours or three business days to process after the written request is received.

Requesters will be notified for additional information if forms are incomplete.

Methodist Health System
Release of Information Department
10060 Regency Circle
Omaha, NE 68114
Hours of Operation: Monday – Friday 8am-4:30pm
Phone# 402-354-4660
Fax# 402-354-1350
NMHS.ROI@NMHS.org*

All entities of Methodist Health System

Methodist Fremont Health
Methodist Jennie Edmundson
Nebraska Methodist Hospital
Methodist Physicians Clinic
Methodist Women's Hospital

* Communications sent by email over the internet are not secure. There is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

For Office Use Only: ☐ HIM to complete

Date Received: _____ Location: _____

MRN: _____ Pg. Count: _____

FIN#: _____ Released By: _____

Printed By: _____ Released Date: _____

☐ Drivers License ☐ Patient ID Band ☐ Work ID Badge ☐ Law Enforcement ☐ Other_____