Document Type: Requests for ROI
Subject: Requests for ROI

ROI001

METHODIST

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 <u>complete</u> addresses):

To: Name _____
Address _____
City/State/Zip _____
Phone/Fax _____ / _____

From: Name _____
Address _____
City/State/Zip _____
Phone/Fax _____ / _____

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)
- ☐ Discharge Summary
- ☐ Laboratory/Pathology Reports
- ☐ Radiology:
  - ☐ Reports
  - ☐ Images (CD only)
- ☐ Entire Medical Record (does not include substance use disorder records)
- ☐ Mental/Behavioral Health Records (excluding psychotherapy notes)
- ☐ Sexually Transmitted Disease Records (including HIV/AIDS)
- ☐ Physical/Occupational Therapy
- ☐ Immunization Records
- ☐ Substance Use Disorder Records
  - ☐ All
  - ☐ Only the following substance use disorder records: _____
- ☐ Medication List
- ☐ Emergency Department Records
- ☐ Billing Records
- ☐ Employee Health Records
- ☐ Other: _____

The purpose of releasing or obtaining the above information is:

☐ Continuity of Care ☐ Insurance/Billing ☐ Legal ☐ Personal ☐ Other: _____

Disclosure Format and Delivery Method:

☐ Electronic (choose one): ☐ *Methodist My Care* Portal ☐ Encrypted Email: _____
☐ CD and/or ☐ Paper ☐ Other: _____
☐ Please Mail

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:

  Nebraska Methodist Health System
  Attention: HIM Department
  825 South 169th Street
  Omaha, NE 68118

- Unless otherwise revoked, this authorization remains valid until its expiration/event date, but not greater than two (2) years. Expiration/Event Date: _____
- 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 <u>may</u> contain information about alcohol/drug abuse, mental/behavioral health, 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)

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

PERMANENT PART OF MEDICAL RECORD