



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

Above is an NMHS Employee: Electronic access to all NMHS health records by employed family member named above. Employees are also encouraged to sign up for Methodist My Care. Methodist My Care is a secure online portal that can help you manage health information, visit methodistmycare.org.

Please fax form to 402-354-8790 for employee access only.

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Abstract (discharge summary, history and physical, operative reports, consultations and test results) | <input type="checkbox"/> Entire Medical Record (does not include substance use disorder records) | <input type="checkbox"/> Substance Use Disorder Records
<input type="checkbox"/> All
<input type="checkbox"/> Only the following substance use disorder records: _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Mental/Behavioral Health Records (excluding psychotherapy notes) | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> Laboratory/Pathology Reports | <input type="checkbox"/> Sexually Transmitted Disease Records (including HIV/AIDS) | <input type="checkbox"/> Emergency Department Records |
| <input type="checkbox"/> Radiology:
<input type="checkbox"/> Reports
<input type="checkbox"/> Images (CD only) | <input type="checkbox"/> Physical/Occupational Therapy | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Employee Health Records |

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 **OR**
 I will pick up at: Methodist Hospital Methodist Women's Hospital Methodist Fremont Health
 Methodist Jennie Edmundson Hospital Methodist Hospital Community Counseling Program

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. The address can be found on page 2 (on the back) of this form.
- Unless otherwise revoked, this authorization remains valid until its expiration date or event, but not greater than one (1) year. 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 may 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 72 hours or three business days to process after the written request is received.

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

**Methodist Health System
Release of Information Department**
8303 Dodge Street
Omaha, NE 68114

Hours of Operation: Monday – Friday 8am-4:30pm
Phone# 402-354-4660
Fax# 402-354-1350
NMHS.ROI@NMHS.org*

Methodist Health Systems Locations for Pickup

Nebraska Methodist Hospital
8303 Dodge Street
Omaha, NE 68114

Methodist Fremont Health
450 E. 23rd Street
Fremont, NE 68025

Methodist Women’s Hospital
707 N. 190th Plaza
Elkhorn, NE 68022

Methodist Jennie Edmundson
933 E. Pierce Street
Council Bluffs, IA 51503

Methodist Hospital Community Counseling Program
9239 W. Center Road
Omaha, NE 68114

* 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.

Methodist Staff Use Only:		<input type="checkbox"/> HIM to release records
		<input type="checkbox"/> Records Released
Date Received: _____	Location: _____	
MRN: _____	Pg. Count: _____	
FIN#: _____	Released By: _____	
Printed By: _____	Released Date: _____	
<input type="checkbox"/> Drivers License	<input type="checkbox"/> Patient ID Band	<input type="checkbox"/> Work ID Badge
<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Other _____	