Great Plains Health

Health Information Management
Release of Information
601 West Leota, North Platte, NE 69101
Phone (308) 568-7440 Fax (308) 568-7396

Patient Name: _____ **Birth date**: _____

Address: _____ **Daytime Telephone**: _____

City: _____ **State:** _____ **Zip:**_____ **Last 4 of SSN#**: _____

I hereby authorize and request release of my medical records:

Please list the name and address of the provider you are requesting records from and the name and address of the provider/facility that you want the records sent to.

FROM: _____ **TO:** _____

_____ _____

_____ _____

_____ _____

Information to be disclosed:

From (date) _____ **To (Date)** _____

o Discharge Summary	o EKG/EEG Reports	o Radiology Images
o History and Physical Exam	o Emergency Room Record	o X-ray Reports
o Operative Report	o Clinic Notes	o Prenatal (Pregnancy) Records
o Pathology Report	o Psychiatric Information	o Physical/Occupational Therapy Notes
o Other (please specify)	o Laboratory Results	o Substance Use Disorder Notes

_____

Release Format (choose one):

o One Chart Patient Portal o Mail o Pick Up o Fax _____

Purpose of Release: o Continuation of Care o Attorney o Personal records o Other _____

This statement of consent can be revoked at anytime before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

PROHIBITION ON REDISCLOSURE OF ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: This information has been disclosed from records protected by federal law. 42 CFR. Part 2 prohibits any further disclosures of these records without specific written authorization of the person to whom it pertains, or as otherwise permitted by law.

I understand Great Plains Health and its affiliates will not condition evaluation or treatment on whether I sign this authorization. Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

_____ _____

Signature of Patient Date

_____ _____

Print Name of parent, guardian, or authorized representative Relationship to patient

_____ _____

Signature of parent, guardian, or authorized representative Date

COPY IS AS VALID AS ORIGINAL

AUTHORIZATION FOR RELEASE OF INFORMATION