# AUTHORIZATION FOR RELEASE OF INFORMATION

Medical Records | M-F 8-4:30 | Phone: 402-644-7602 | Fax: 402-644-7510

**** Indicates must be filled out completely**

**1.**This release is regarding the following patient:**

Patient Name ________________________________________ Phone # ________________________

Previous Name(s) ____________________________________ Date of Birth ______________________

Address __________________________________________ SSN# _________-_________-_________

**2. **I give my permission for Faith Regional Health Services/Physician Services to do either of the following: (Please check one)**

☐ **Release** my records **to**: (yourself, your spouse, different provider, insurance company, etc.)
☐ **Request** my records **from**: (Another facility you would like FRHS to obtain records from)

| | |
|---|---|
| **Name:** ______________________________________ | **Method of Delivery**: (please choose one) |
| **Address:** ____________________________________ | ☐ Mail to: ______________________ |
| **Attention to:** _________________________________ | ☐ Fax to: ______________________ |
| **Phone #:** ____________________ **Fax #:** ____________________ | ☐ Picking up on: (photo ID is required) ______________ |

**3. **Date(s) of service needed:** ______________________________________________

**4. **Records to be released:**

| | | |
|---|---|---|
| ❑ Discharge Summary | ❑ Operative/Pathology Report | ❑ Cardiology Reports |
| ❑ History & Physical | ❑ Consultations | ❑ X-ray CD |
| ❑ Emergency Room Report | ❑ Radiology Reports | ❑ Other ____________________ |
| ❑ Progress Notes | ❑ Lab Reports | |

**5. ** I *further authorize* the release of my information that relates to: (please initial each as it applies to you)**

❑ Chemical Dependency/ Substance Abuse ______ ❑ Mental Health notes/testing ______
❑ HIV/AIDS Testing/Treatment_____

**6. **Purpose of this release:**

❑ Continuing Care ❑ Insurance ❑ Attorney ❑ Personal Use ❑ Other________________________

**Statement of Authorization:**

- I understand that, except for research and related treatment, FRHS will not condition my treatment on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once the information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

______________________________________ ______________________
**Signature of Patient/Legally Authorized Representative Date

______________________________________ ______________________
Relationship to Patient Reason Patient Unable to Sign

______________________________________ ______________________
Signature of Witness (Verbal Authorization Only) Signature of Witness (Verbal Authorization Only)

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Records released by: ____________________ Date mailed/faxed/picked up: ____________________

MRN:______________

PATIENT LABEL HERE

OFFICE USE ONLY