Sidney Regional MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

There will be a fee charged for this service, unless used for further medical treatment.

1. **Patient's Name:**_____ **Date of Birth:**_____

   Address:_____ **Phone #:**_____

   City:_____ **State:**_____ **Zip Code:**_____

2. **I hereby authorize the release of my Protected Health Information (PHI)**

   FROM: _____Sidney Regional Medical Center (Hospital) Other (please specify):_____
   _____Sidney Regional Medical Center (Physicians Clinic)

   TO:_____
   Recipient Name **Address**

   City:_____ **State:**_____ **Zip Code:**_____

3. **Information to Be Released – Covering the Periods of Health Care:**
   From (date):_____ To (date):_____

   Please check the type of information to be released:

_____Pertinent Documentation	_____Operative Report	_____Lab Results	_____Complete Health Record
_____History and Physical	_____Consultation Reports	_____Progress Notes	_____EKG
_____Discharge Summary	_____X-ray Reports	_____X-ray Films/Image	_____EEG
_____Photographs/Surgical	_____Complete Billing Record	_____Itemized Bill	_____Physician Office Notes

   Other, (specify):_____

   Purpose of Request

_____Personal	_____Billing or Claims Payment	_____Work Comp	_____Insurance/Reimbursement

   Other, (specify):_____

4. **Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIVA/AIDS Records Release**

   I understand that if the information in my health record includes information relating to behavioral or mental health services, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), I agree to its release.
   Check One: _____YES _____NO

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions), that those records are protected by Federal Law. The Authorization for Release of Information for does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug Abuse, prohibit information disclosed from records protected by this law form being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

1000 Pole Creek Crossing – Sidney, NE 69162 – Phone: 308-254-5825 – FAX: 308-254-2672 – SidneyRMC.com

Time Limit & Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at (SRMC, 1000 Pole Creek Crossing, Sidney, NE 69162). Unless revoked, this authorization will expire of the following date or event _____, or ONE YEAR from date of signature, unless otherwise specified.

Re-disclosure
I understand that once information is release to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protested by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request.

5. Payment
According to Nebraska State Statutes, LB 17, SRMC may charge reasonable fees for copies of medical records. Alternatively, we may provide you with a summary of explanation of your health information as long as you agree to that, and to its cost, in advance. If you indicate above that you would like a summary of your health information, we will inform you of the cost for that summary prior to providing you with the summary. If you do not agree to the charge, we will not prepare the summary.
Authorization must be signed by the patient or by parent/legal guardian of a minor, or by the legal representative when the patient lacks the decisional capacity, or if the parents are physically unable to sign but mentally understand and consent.

Authorization Approval & Receipt of Acknowledgment: I hereby authorize the use or disclosure of my personal health information described in this authorization and acknowledge receiving a signed copy of this authorization. I understand that if anyone who receives my health information is not a healthcare provider or a health plan, my health information may not be protected by federal privacy laws if my health information is redisclosed by that recipient person or Sidney Regional Medical Center.

Patient's Signature:_____ Date:_____

Authorized Representative Name: _____Relationship to Patient:_____
Please Print Parent/Legal Guardian

Authorized Representative Signature:_____ Date:_____

Please indicate reason patient could not sign:_____

Photo ID Required/Obtained:_____

Witness:_____ Date:_____

Information sent/released on: Date:_____ By: _____

Notarization: On this _____ day of _____, 20_____, the said _____ is known to me (or satisfactorily proven) to be the person named in the foregoing instrument, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein. I hereunto set my hand and official seal.
(Required if form is completed off site)

_____
Notary Public

ORIGINAL: FACILITY PHOTO COPY: PATIENT

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