Sidney Regional MEDICAL CENTER

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

1. **Patient's Name:** _____ **Birth Date:** _____
   Address: _____ **Phone:** _____
   City: _____ **State:** _____ **ZIP:** _____

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**

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

Please check type of information to be released:

__ Pertinent documentation	__ Operative reports	__ Lab results	__ Complete health record
__ History and physical	__ Consultation reports	__ Progress notes	__ EKG
__ Discharge summary	__ X-ray reports	__ X-ray films/images	__ EEG
__ Photographs-surgical	__ Complete billing record	__ Itemized bill	__ Physician office notes

Other, (specify)_____

☐ Inspection of electronic PHI records

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 HIV/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, and 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 does not authorize for re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug Abuse prohibits information disclosed from records from being re-disclosed, 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.

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Sidney Regional MEDICAL CENTER

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 on the following date or event _____, or ONE YEAR from date of signature unless otherwise specified.

Re-disclosure

I understand that once information is released 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 the "Purpose of Request" above.

5. Payment

According to Nebraska State Statutes, LB 17 Nebr, 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, the parent/legal guardian of a minor, or the legal representative when the patient lacks the decisional capacity or is physically unable to sign but mentally understands and consents.

Authorization Approval & Receipt of Acknowledgment: I hereby authorize the use or disclosures 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 health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is re-disclosed 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: _____

ORIGINAL: FACILITY PHOTO COPY: PATIENT

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NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

Sidney Regional Medical Center (SRMC) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sidney Regional Medical Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sidney Regional Medical Center:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Language Line at 800.752.6096, option 1, 24 hours a day, daily.

If you believe that Sidney Regional Medical Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Compliance Officer at Sidney Regional Medical Center, 308.254.5825 ext. 1440, fax 308.254.8080. You can file a grievance in person, by mail, or by fax. If you need help filing a grievance, the Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/filing-with-ocr/index.html.

ATTENTION: If you speak [insert language], language assistance services, free of charge, are available to you. Call 800.752.6096, option 1.

SPANISH ATENCIÓN: si habla Española, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800.752.6096.

VIETNAMESE CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800.752.6096.

CHINESE 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800.752.6096.

ARABIC ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800.752.6096, رقم هاتف الصم والبكم(

KAREN ပာ်သူဉ်ပာ်သး– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနး့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး

FRENCH ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800.752.6096.
CUSHITE-OROMO: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800.752.6096.

GERMAN ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800.752.6096.

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.752.6096. 번으로

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전화해 주십시오.

NEPALI: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको ननम्तत भाषा सहायता सेवाहरू ननिःशुल्क रूपमा उपलब्ध छ । फोन गनुहोस् 800.752.6096.

RUSSIAN: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800.752.6096.

LAOTIAN: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800.752.6096.

KURDISH ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 800.752.6096 بکە.)

FARSI: **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800.752.6096 تماس بگیرید.

JAPANESE: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800.752.6096 まで、お電話にてご連絡ください。

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