AUTHORIZATION FOR RELEASE OF INFORMATION

FAITH REGIONAL HEALTH SERVICES

2700 W Norfolk Ave. Norfolk, NE. 68701

❑ **I Hereby Authorize Faith Regional Health Services to RELEASE information TO:**

Name: _____ Phone #: _____

Address: _____

❑ **I Hereby Authorize Faith Regional Health Services to REQUEST information FROM:**

_____

(Facility Name and Address)

Regarding the Following Patient:

Patient Name _____ Phone # _____

Other Names _____ Date of Birth _____

Address _____ SSN# _____-_____-_____

Date(s) treatment was received: _____

Records to be released:

❑ Discharge Summary ❑ Operative Report ❑ EMG Report ❑ Progress Notes
❑ Consultation ❑ Pathology Report ❑ EKG Report ❑ X-ray CD
❑ Emergency Room Report ❑ X-ray Report ❑ History & Physical ❑ Other _____
❑ Laboratory Report ❑ Birth/Delivery Records

I authorize the release of information relating to (please initial):

❑ Chemical Dependency or Abuse _____ ❑ Psychiatric Evaluation/Treatment _____
❑ HIV/AIDS Testing/Treatment_____ ❑ Psychotherapy Notes _____

Purpose of 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)

FOR OFFICE USE ONLY

Medical Records Released By: _____

Date Records Mailed/Faxed/Picked Up: _____ MR#:_____

PLACE PATIENT LABEL HERE

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