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)

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

MRN:_____

LG0005NSG084 09/2020

HIM ROI Authorization

OFFICE USE ONLY

PATIENT LABEL HERE