METHODIST PHYSICIANS CLINIC

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please read carefully before signing and dating.
All sections must be complete to be HIPAA compliant.

| *Cont Care, Images:* | *For ROI Office Use Only:* |
|---|---|
| Date: _____ | Date Rcd: _____ |
| Records Released: _____ | Pt#: _____ |
| _____ | C Loc: _____ |
| _____ | Order #: _____ |
| _____ | Date Compl & Init: _____ |
| Sent By: _____ | Spec. Inst: _____ |

**(1) Patient Name:** _____ **Birthdate:** _____
(PLEASE PRINT) LAST FIRST M.I.

Have you ever used another name (*maiden, adopted, nickname, etc.*)? ☐ No ☐ Yes _____

**Address:** _____

**SSN: (last 4-digits)** _____ **Phone#(s):** _____

**(2) INFORMATION TO BE RELEASED *BY*:**
INDICATE EACH SPECIFIC CLINIC OR PROVIDER

ORGANIZATION, CLINIC OR PROVIDER

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

**(3) INFORMATION TO BE RELEASED *TO*:**
REQUEST MUST HAVE COMPLETE ADDRESS

ORGANIZATION, DOCTOR OR NAME

STREET ADDRESS

CITY, STATE, ZIP

PHONE FAX

**(4) INFORMATION AUTHORIZED TO RELEASE:** (*Choose only one*)
For Patient Requests: includes, but is not limited to, office notes, H&P, tests and some nursing notes.

☐ **ALL MEDICAL RECORDS/DATES** *Patient Requests for all records may be partially executed to assist in continuation of care.*

☐ **Medical Record for following dates:** _____ THRU _____

☐ **Specific Information:** _____

☐ ***For Employees Only:*** **Access to all MHS electronic health records by Employed Family Member** (viewing only).

**(5) TYPE OF RECORDS** (CHOOSE ONE): ☐ Medical ☐ Diagnostic Images

**(6) PURPOSE:** ☐ PERSONAL ☐ MVA/INJURY ☐ HEALTH CLAIM ☐ WORK COMP ☐ TRANSFER OF CARE ☐ LEGAL
☐ CONTINUATION OF CARE ☐ INSURANCE APPLICATION ☐ SS DISABILITY ☐ LONG/SHORT TERM DISABILITY

**Note:** There may be a charge for copies of medical records unless being sent to another physician or healthcare facility.

**(7)** This authorization will be valid for 365 days from the date it is signed or until _____, whichever is shorter. This authorization may be revoked at any time by notifying the above named provider of information, in writing, except when this authorization was obtained as a condition of obtaining insurance coverage. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. MHS and its affiliates cannot condition treatment based on signature on authorization for disclosure. Information used/disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. This may include records created after the date of signature, if not expired.

**(8) INFORMATION PROTECTED BY STATE AND FEDERAL LAW**
I understand that the information released from my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or gene related impairments, including genetic testing. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby authorized to release all information/records related to such diagnosis, testing, treatment, unless specifically excluded on the line below:

EXCLUSIONS: _____

**9) LEGAL SIGNATURE:** _____ **DATE:** _____
Parent/Legal Guardian must sign if patient is a minor.: NE under age 19; IA under age 18 **Required: Attach Legal Documentation (POA, guardianship)**

**(10) PRINTED NAME:** _____

**(11)** *If other than self, relationship to the patient:* _____ (OVER)

**(12) METHOD** (CHOOSE ONE): ☐ Paper ☐ CD (may be encrypted) ☐ Email *(to patient's personal email address)*

The section below must be completed or you will automatically receive paper records.

***EMAIL/ELECTRONIC DELIVERY NOTICE:***

*I understand emails can be intercepted, altered, forwarded, or used without authorization. Emails can be circulated, forwarded, and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed and lost during creation and transmission due to technical failure. I understand and accept the risk using an unsecure email. I agree for Methodist Physicians Clinic and CiOX to email instructions on how to retrieve my protected health information when the email delivery method is chosen. I fully understand the risk involved in using the email delivery method for said access to my protected health information.*

**PLEASE SIGN IF YOU AGREE AND ACKNOWLEDGE:** _____

*(Signature)*

**PLEASE PROVIDE AN EMAIL FOR ELECTRONIC DELIVERY**

## Instructions for Authorization

*Explanation and help for patients when filling out this authorization form.*

**(1)** Print name of patient, birth date, full address (including city, state and zip code), the last 4 digits of the Social Security number, any names the patient previously used, and daytime phone number for whom the medical records are being requested.

**(2)** Indicate the name(s) of the clinics(s) and/or provider(s) that you are authorizing information to be released from. We require separate requests for each clinic/department for which you need records.

**(3)** Indicate the name of the person, clinic or company that you are authorizing to receive the records, view the information *(employees)*. **IMPORTANT: We cannot process requests without a full address.**

**(4)** Check boxes to indicate what information is to be disclosed:

a. All Medical Records/Dates: 1) Mark this box to indicate all dates of treatment. 2) For patient requests this would include, but not be limited to, office notes/History & Physicals, essential nursing notes and any diagnostic tests ordered by our MPC provider(s). 3) **Please note that a patient request for all dates of service may be partially executed.** 4) Complete patient records may be released to an attorney's office upon receipt of a formal request when authorized. **NOTE:** Hospital records must be requested from NMHS Hospital medical records departments: MH/WH: 402-354-4657/402-354-4658 JE: 712-396-7248.

b. Complete medical record for following dates: Mark this box if only certain dates of records should be sent. The same rules apply as in (a-2). This box cannot be marked for viewing purposes.

c. Specific Information: Mark this box if only a specific date of service or type of document should be sent (e.g. only office notes or mammogram reports). The same rules apply as in (a-2). This box cannot be marked for viewing purposes.

d. Electronic Access to All MHS: Mark this box to give an MPC employee access to view your records. This is to VIEW only.

**(5)** Indicate what type of record/information is being requested for distribution to appropriate department for fulfillment.

**(6)** Check the box that applies to the reason/purpose the medical record/information is being requested.

**(7)** Read the patient authorization section before signing. Per state law the authorization is valid up to 365 days.

**(8)** Please read the acknowledgement of authorization to release State and Federal protected information and indicate any restrictions that you do not want released. This does not apply to viewing of medical records.

**(9)** Sign your full legal signature, do not use initials, and indicate the date signed.

**(10)** Print full legal name.

**(11)** Indicate your relationship to the patient. If you are signing as the patient's medical Power of Attorney (POA) or current legal guardian a copy of a valid medical POA or guardianship paperwork needs to be attached.

**(12)** Indicate the preferred method of delivery – choosing only one – paper, encrypted CD or email. (**NOTE:** a CD requires a computer with a CD player to be viewed. The CD may be encrypted). (Charges still apply.)

**Methodist Physicians Clinic Release of Information**
**10060 Regency Cir.**
**Omaha, NE 68114**

**Phone: 402-354-1494** **Fax: 402-354-1350**
**Email: roi@nmhs.org**

**Please do not send medical records to our department.**

**Please call us with any questions 8-5 Monday-Friday (closed 12-1)**