NEWMAN REGIONAL HEALTH

Hospital Ph: 620-343-6800 Fax: 620-340-6767|Clinic|Express Care Ph: 620-343-2376 Fax: 620-343-0095

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations. If any section is incomplete, this form may be invalid.

PATIENT INFORMATION:

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone #:** _____

Social Security # (optional): _____ **Patient M#:** _____ **Patient F#:** _____

I authorize information to be released: □ From □ To	**I authorize information to be released: □ From □ To**
□ Newman Regional Health (Hospital Records) □ Newman Regional Health Express Care □ Newman Regional Health Occupational Health □ Newman Regional Health Cardiology Clinic □ Newman Regional Health ENT Clinic □ Newman Regional Health Family Medicine Clinic □ Newman Regional Health Orthopedics & Sports Medicine Clinic □ Newman Regional Health Pediatric Clinic □ Newman Regional Health Psychiatry Clinic □ Newman Regional Health Surgical Specialists Clinic □ Newman Regional Health Hand in Hand Hospice □ Newman Regional Health Medical Equipment & Supply	**Name:** _____ **Address:** _____ **City/State/Zip:** _____ **Phone #:** _____ **Fax #:**_____

REQUEST DELIVERY:

□ Fax □ Encrypted e-mail | □ Pick up □ US Mail **Media:** □ Paper Copy □ USB Drive □ CD

PURPOSE OF DISCLOSURE:

□ Treatment/Continued care □ Relocating □ Insurance Purposes □ Legal Purposes □ Personal Reasons □ Other:

Description of information to be used or disclosed:

Dates of Service From: _____ Through: _____

HOSPITAL RECORDS			***CLINIC RECORDS***
□ All PHI in medical record	□ Discharge Records	□ Physician Progress Notes	□ All PHI in medical record (past 3 years only)
□ Anesthesia Records	□ Laboratory Records	□ Physician Orders	□ Immunizations only
□ Social Work Records	□ Lab Specimen/Slide	□ Respiratory Therapy Notes	□ Billing Records only
□ Consultation Reports	□ Nursing Notes/Records	□ Radiology Films	□ Radiology Images on CD
□ Diagnostic Test Reports	□ Operative Reports	□ Itemized Bills	□ Only Information related to: _____
□ ER Reports	□ Pharmacy Records	□ UB-04	_____
□ History & Physical	□ PT/ST/OT Records	□ Other:	□ Other:

I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse (CFR 42).

I understand that I may refuse to sign this authorization and understand that it is strictly voluntary; however NRH cannot honor my request to release information or records without a signed authorization. See 45 CFR 164.514(b)(1). My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. Records within the scope of this authorization (check marked above) may be disclosed pursuant to this authorization. Subsequent records will not be automatically released. If subsequent records within the scope of this authorization are requested, the patient or recipient is responsible for notifying NRH of such request. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it, if requested.

Section B: The request of PHI is for the purpose of marketing

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? □ Yes □ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated. This authorization expires 6 months from the date signed. If you prefer this authorization to expire before 6 months from today please list the expire date here: _____

Signature of Patient/Patient Representative: _____ Date: _____

Print Name of Patient's Representative: _____ Relationship to Patient: _____

Internal Use:

Witness Signature:	Date Copied:	Date Logged:	Date Released:
Specific Records Released:	Type of ID:	Copied By:	# Pages: