Newman Regional Health
Patient Authorization for Release of Protected Health Information (PHI)
Ph: 620-343-6800 Fax: 620-340-6767 Email: portalHIM@newmanrh.org

All Sections of this form must be completed to be valid. A photo ID will be required.
Patient Name:_____ Date of Birth:_____
Name at Time of Treatment (if different from above)_____
Address:_____ City/State :_____ Zip Code:_____
Email Address:_____Phone:_____
I request my records from:

Newman Regional Health:
□ Hospital □ Medical Equipment
□ Newman Therapy Services □ Hand in Hand Hospice
□ Newman Psychiatry Clinic □ Newman ENT Clinic
Other:_____

Newman Regional Health Medical Partners:
□ Family Medicine Clinic □ Pediatric Clinic
□ Express Care □ Occupational Health
□ Cardiology Clinic □ Surgical Specialists
□ Orthopedics Clinic

I request my records to be sent to:
Name: _____Email:_____
Address:_____Phone:_____
City/State:_____ Zip:_____ __ Fax# (medical facility only):_____

What records do you want?
□ Emergency Room Record
□ Laboratory Report(s)
□ Office Visit Notes
□ Detailed Billing
□ Hospital Visit Summary
□ Radiology Report(s)
□ Immunization(s)
□ Complete Medical Record
□ Operative Record
□ Radiology Images on CD
□ PT/ST/OT Records
Other:_____
_____

Covering the period of healthcare from:
□ Specific Dates: _____to_____ **OR** □ Other_____

Records are needed by:
□ Specific Date:_____
□ As soon as possible (within 30 days)

Purpose for Request (optional):
□ Legal □ Insurance
□ Personal □ Continuation of Care

How would you like your records delivered?
□ **Paper:** □ US Mail □ Pick up in person
□ **Electronic:** □ Secure email □ USB Drive

By signing this authorization form, I understand that:
- Requests for copies of medical records may be subject to copying fees.
- PHI may include records relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire six months from date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re disclosure, and the information may not be protected by federal confidentiality rules.

Signature: If signed by an authorized representative, supporting legal documentation must accompany this form.

Patient /Representative Signature: _____Date:_____

Printed Name of Representative: _____Relationship to Patient:_____

Internal Use Only

Witness Signature:	Released By and Date:	Type of ID:
Fees:	Payment Type:	# Pages:
Records Released:	Printed By and Date:	Logged:
M#:	F#/A#:	

Newman Regional Health
www.newmanrh.org

Instructions for Medical Records Request:

1. For immediate access to your medical records at no charge, please visit your Newman Regional Health Patient Portal at www.newmanrh.org .
2. For all other requests, please complete the following online form and submit along with your photo ID. This form may also be printed and returned by fax to 620-340-6767, by email to portalHIM@newmanrh.org, or by mail to : Newman Regional Health, Attn: HIM, 1202 W. 12th Ave. Emporia KS 66801.
3. All requests must be received with a copy of your photo ID. When picking up records in person, a photo ID must also be presented.
4. Records that exceed 30 pages will be charged a fee of $0.63 for each additional page. A USB Drive with unlimited pages is available for $6.50.
5. You will receive a phone call within 30 days, when your request is completed.
6. For questions, please contact the Health Information Management Department Mon. – Fri. 8:00 am to 4:30pm. Phone: 620-343-6800, ext. 2625. Email portalHIM@newmanrh.org .