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 https://www.newmanrh.org/my-health-records/.
2. For records not available on the portal or for patients without a portal account, please use our online records request tool at https://www.newmanrh.org/my-health-records/ .
3. For all other requests, please complete the following form and submit with a copy of your photo ID. This form may be returned in person to Main Registration (Entrance C), by fax to 620-340-6767, by email to portalHIM@newmanrh.org, or by mail to : Newman Regional Health, Attn: HIM, 1201 W. 12th Ave. Emporia KS 66801.
4. You will be contacted when your records are available. This may take up to 30 days.
5. When picking up records in person, a photo ID must be presented. Records can be picked up when ready at Main Registration (Entrance C).
6. Records that exceed 30 pages will be charged a fee of $0.63 for each additional page. Records on microfilm (anything before 2006) will be charged $1.75 per page. A USB Drive with unlimited pages is available for $6.50.
7. 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 .

Newman Regional Health

Patient Authorization for Release of Protected Health Information (PHI)

Ph: 620-343-6800, ext. 2625 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 ☐ Newman Medical Equipment

☐ Newman Therapy Services ☐ Hand in Hand Hospice

Other: ____

Newman Regional Health Medical Partners:

☐ Family Medicine ☐ Pediatric ☐ Orthopedics

☐ Express Care ☐ Cardiology

☐ Occupational Health ☐ Surgical Specialists

____

I request my records be sent to:

Name: ____Email:____

Address:____Phone:____

City/State:________________________ Zip:____________ __ Fax# (medical facility only):_________________________

What records do you want?

☐ Continuity of Care Document ☐ Detailed Billing

☐ Emergency Room Record ☐ Hospital Visit Summary ☐ Operative Record

☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Radiology Images on CD

☐ Office Visit Notes ☐ Immunization(s) ☐ 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?

☐ **Secure Email:** (Email listed above) ☐ **Fax:** (# listed above)

☐ **Paper via US Mail** ☐ **Paper Pick up in person** (Entrance C)

☐ **USB Drive via US Mail** ☐ **USB Drive Pick up in person**

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 behavioral/mental health care, STDs, 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

Released By:	Date:	Prepared By:	Date:
Fee:	Payment Type:	Logged:	Record Type:
ID Type:	ID Checked:	M#:	F/A#: