Newman Regional Health

Patient Authorization for Release of Protected Health Information (PHI)

1201 W. 12th Ave., Emporia, KS 66801
Ph: 620-343-6800, ext. 22625 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 Documents □ 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 v12.19				
	ID Type:	ID Checked By:	Fee:	Payment Type:
	Prepared By/Date:	Logged by/ Date:	Record Type:	
	M#	F/A#:		

Released by: _____ Date:_____