AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information will be available within a minimum of 5 working days and a maximum of 30 calendar days.
There may be a charge for this service.

THIS FORM MUST BE FILLED OUT COMPLETELY

Patient Name_____ **Date of Birth** _____

Address _____ **(City/State/Zip)** _____

Daytime number where you can be reached (_____) _____ or (_____) _____

Purpose of Disclosure

☐ Patient Request ☐ Continued Care ☐ Insurance ☐ Attorney ☐ Finance ☐ Social Security Benefits/Claim
☐ Other (Description) _____

Release Information From	**Release Information To**
☐ **Regional West Medical Center** 4021 Ave B, Scottsbluff, NE 69361 *Fax* (308)630-1094 *Phone* (308)630-1194 ☐ **Regional West Physicians Clinic** ***Clinic/Physician*** _____ ☐ Other Facility/Provider _____ Fax _____ Phone _____	☐ **Regional West Medical Center** 4021 Ave B, Scottsbluff, NE 69361 Fax _____ Phone_____ ☐ **Regional West Physicians Clinic** Fax _____ Phone_____ ☐ **Patient at the same address listed above** ☐ By Mail ☐ For Pick-up ☐ Other _____ Name _____ Address / Phone#

Covering the date(s) of service From _____ To _____
Month/Day/Year Month/Day/Year

Medical Record to be released as ☐ Paper or ☐ Other _____ *Radiology Images will be released on a separate CD

Information to be Disclosed

☐ History and Physical	☐ Operative Notes	☐ Cardiology	☐ Radiology Images	☐ Pathology Reports
☐ Progress Notes	☐ Emergency Report	☐ Physical Therapy	☐ Radiology Reports	☐ Clinic Records
☐ Discharge Summary	☐ Consultations	☐ Billing	☐ Lab Reports	☐ Clinic Radiology Images
☐ Dismissal Instructions	☐ Other_____			

Disclosure Requiring Special Consent of Sensitive Information

I understand that the information in my health record may include information relating to behavioral or mental health services, developmental disabilities, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). I authorize the release of this information to the party listed above.

Check one ☐ Yes ☐ No

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Without my express revocation, this authorization will expire in 180 days from date of signature. A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient or legal representative.

I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form.

I understand that I may inspect or copy the information to be used or disclosed, as provided in 45CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy laws or regulations. If I have questions about disclosure of health information, I can contact the Health Information Management department at RWMC.

Signature (Patient or Legal Representative)_____ Date _____

If other than the patient, indicate relationship ☐ Parent ☐ Guardian/Legal Representative/POA (Circle One)
Copy of legal document appointing representation must be provided.

Office Use Only

Identity of patient and/or signature verified via ☐ Photo ID ☐ Matching signature ☐ Other _____

Verified by _____ Date _____ Request completed by _____ Date _____

Notes

Regional West Medical Center
4021 Avenue B | Scottsbluff, NE 69361 | 308.635.3711
Regional West Physicians Clinic

For Patient Label Use Only

Original – Chart
Yellow – Requestor