CONSENT TO RELEASE OF INFORMATION
Memorial Community Hospital and Health System
Health Information Management Department: 810 N. 22nd, Blair, NE 68008

Patient's Legal Name _____ **Birth Date** _____

By completing this document, I am allowing ☐ Blair Clinic ☐ Fort Calhoun Clinic ☐ Cottonwood Clinic ☐ Memorial Community Hospital to release medical information concerning the above-named patient to the person or facility listed below.

_____
Name of Person and/or Facility who will receive information.

_____
Complete mailing Address/Street/PO Box City, State, Zip Code Phone

Check the information to be disclosed (**include dates if known**): _____Minimum necessary, or specify as follows

_____ Medication List
_____ History and Physical
_____ Discharge Summary
_____ Respiratory
_____ Consultation Reports
_____ Billing Information
_____ Other
_____ Immunization record
_____ Radiology Reports and/or film
_____ Lab
_____ Photographs, videotapes, digital or other images
_____ Physical Therapy
_____ Home Health Care
_____Problem list
_____Allergy List

I understand that this will include information relating (check if applicable):

_____ HIV related information _____ Alcohol and/or drug abuse _____ Behavioral health services/psychiatric care

Covering the period(s) of healthcare FROM (date) _____ TO (date) _____ **(A maximum of 2 years will be released unless otherwise specified)**

Purpose: The purpose of the requested use or disclosure is: _____

_____

My Rights: I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility benefits. This consent is voluntary. If I cancel this consent at a later date, I must send written notification to the Health Information Manager at the address above. I have a right to receive a copy of this authorization.
If this consent is cancelled, I understand that information may have been released prior to the cancellation, and that action would not be considered a breach of confidentiality. I also acknowledge that: 1) recipients of this information may possibly re-release information without proper authorization, and 2) once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask question by contacting the Manager of Health Information Management at the above address.

This agreement will expire 90 days from the date of signature, or as indicated (specify number of days or months) _____ unless cancelled by the patient/guardian.

<u>All areas must be completed or the release will be denied.</u>

_____ _____ _____
Signature of patient or Legal Guardian Printed name Date

_____ _____ _____
Complete Mailing Address

_____ _____
Relationship if not patient Witness

Info sent: _____ Recorded in PHI tracking system: _____
Name/Department Name/Department