

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please Allow At Least 5 Working Days For Records To Be Prepared. There May Be A Charge For This Service.

Patient Name _____ Date of Birth _____

Address _____

Day time Phone Number or number where we can reach you () _____

1. REQUEST RECORDS FROM

Regional West Medical Center, 4021 Ave B Scottsbluff, NE 69361

Other _____

2. RELEASE RECORDS TO Regional West Medical Center, 4021 Ave B Scottsbluff, NE 69361

Patient at the same address as above By Mail or For Pick-up

Other (include name, address, phone#) _____

3. Purpose At the request of the Patient Continued Care Attorney Finance
 Other _____

Covering the dates(s) of service From _____ To _____

4. I would like the following information released

___ History and Physical ___ Discharge Summary ___ Operative Notes ___ Progress Notes ___ Home Meds List
___ Emergency Report ___ Dismissal Instructions ___ Social History ___ Lab ___ Physical Therapy
___ Counselors Summary ___ Psychological Evaluations ___ Consultation ___ Radiology ___ Other _____

5. 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

I understand that if the information in my health record includes information relating to behavioral or mental health services, 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 agree to its release. **Check one**
___ Yes ___ No

- A. Authorization, 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, except to the extent that action has already been taken to comply with it.
- B. 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.
- C. Re-Disclosure, I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

6. SIGNATURE Patient _____ Date _____

7. If other than the patient, indicate relationship ___ Parent ___ Guardian / Legal Representative/POA (circle one)
Identity of Patient and / or Signature Verified via ___ Photo ID ___ Matching Signature ___ Other _____
Verified by _____ Date _____

Office Use Only This request was completed by _____ Date _____ # _____

