3.4 - Authorization For Release of Health Information

ROI

Patient ID: _____
For Office Use Only

Valley County Health System
Hospital - Medical Clinic - Home Health
2707 L St.
Ord, NE 68862

308-728-4200 - Valley County Health System Main Line
308-728-3671 - Health Information Department Fax

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____ MRN #: _____

Release Records TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Release Records FROM:

Only complete if requesting records to be sent to Valley County Health System

Provider: _____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Purpose of Release:

- ❑ Patient Request
- ❑ Transfer to another clinc
- ❑ Other (Please Specify): _____

Dates of Service or Time Period to be Disclosed:

- ❑ Current Calendar Year
- ❑ Dates Of Service: _____
- ❑ Other: _____

Information to be Disclosed:

	Hospital			
❑ Medical Clinic	❑ History & Physical Examination	❑ Consultation Reports	❑ Progress Notes	❑ Other
❑ Home Health	❑ Emergency Room Record	❑ Radiology Reports	❑ Therapies (PT, OT, ST)	❑ Immunization Record
	❑ Discharge Report	❑ Lab Reports	❑ EKG/Cardiac Records	❑ Financial Record
				❑ _____

I specifically authorize the release of information relating to:

- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental Health
- ❑ HIV/AIDS related information (including test results)

I Understand and Acknowledge That:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at the Valley County Health System
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or Federal law.
3. This authorization is effective for the *current calendar year* in which this form was signed. I understand that I may revoke this authorization at any time by giving written notice to the Valley County Health System. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document.
5. *I realize I will be charged a copy fee of: 0:50 cents per page over 100 pages.* Signature: _____

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date

_____ _____
Relationship to patient if signed by personal representative Date

Approved: 10/11; 3/17 **MR-62**