

# NEWMAN REGIONAL HEALTH

Hospital Ph: 620-343-6800 Fax: 620-340-6767 / Clinic / Express Care Ph: 620-343-2376 Fax: 620-343-0095

## Authorization for Release of Protected Health Information (PHI)

<b>Section A: This section must be completed for all Authorizations. If any section is incomplete, this form may be invalid.</b>			
<b>Patient Name:</b>		<b>Birth Date:</b>	<b>Social Security No. (optional):</b>
<b>Patient Phone #:</b>		<b>Patient M#:</b>	<b>Patient F#:</b>
<b>I authorize information to be released:</b> <input type="checkbox"/> From <input type="checkbox"/> To		<b>I authorize information to be released:</b> <input type="checkbox"/> From <input type="checkbox"/> To	
<input type="checkbox"/> Newman Regional Health (Hospital Records) <input type="checkbox"/> Newman Regional Health Express Care <input type="checkbox"/> Newman Regional Health Occupational Health <input type="checkbox"/> Newman Regional Health Cardiology Clinic <input type="checkbox"/> Newman Regional Health ENT Clinic <input type="checkbox"/> Newman Regional Health Family Medicine Clinic <input type="checkbox"/> Newman Regional Health Orthopedics & Sports Medicine Clinic <input type="checkbox"/> Newman Regional Health Pediatric Clinic <input type="checkbox"/> Newman Regional Health Psychiatry Clinic <input type="checkbox"/> Newman Regional Health Surgical Specialists Clinic		<b>Recipient's Name:</b> _____ <b>Address:</b> _____ <b>City/State/Zip:</b> _____ <b>Phone #:</b> _____ <b>Fax #:</b> _____ <input type="checkbox"/> Newman Regional Health Hand in Hand Hospice <input type="checkbox"/> Newman Regional Health Medical Equipment & Supply	
<b>REQUEST DELIVERY:</b>			
<input type="checkbox"/> Fax	<input type="checkbox"/> Encrypted e-mail	<input type="checkbox"/> Pick up	<input type="checkbox"/> US Mail
		<b>Media:</b>	<input type="checkbox"/> Paper Copy <input type="checkbox"/> USB Drive <input type="checkbox"/> CD
<b>PURPOSE OF DISCLOSURE:</b>			
<input type="checkbox"/> Treatment/Continued care <input type="checkbox"/> Relocating <input type="checkbox"/> Insurance Purposes <input type="checkbox"/> Legal Purposes <input type="checkbox"/> Personal Reasons <input type="checkbox"/> Other:			
<b>Description of information to be used or disclosed:</b>			
<b>Dates of Service From:</b> _____		<b>Through:</b> _____	
<b>HOSPITAL RECORDS</b>		<b>CLINIC RECORDS</b>	
<input type="checkbox"/> All PHI in medical record	<input type="checkbox"/> Discharge Records	<input type="checkbox"/> Phys Progress Notes	<input type="checkbox"/> All PHI in medical record (past 3 yrs only)
<input type="checkbox"/> Anesthesia Record	<input type="checkbox"/> Laboratory Records	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Immunizations only
<input type="checkbox"/> Social Work Records	<input type="checkbox"/> Lab Specimen/Slide	<input type="checkbox"/> Respiratory Therapy Notes	<input type="checkbox"/> Billing Records only
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Nursing Notes/Records	<input type="checkbox"/> Radiology Films	<input type="checkbox"/> Radiology Images on CD
<input type="checkbox"/> Diagnostic Test Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Itemized Bill:	<input type="checkbox"/> Only Information related to:
<input type="checkbox"/> ER Records	<input type="checkbox"/> Pharmacy Records	<input type="checkbox"/> UB-04:	_____
<input type="checkbox"/> History & Physical	<input type="checkbox"/> PT/ST/OT Records	<input type="checkbox"/> Other:	<input type="checkbox"/> Other: _____
<i>I understand that requested information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse (CFR 42).</i>			
I understand that I may refuse to sign this authorization and understand that it is strictly voluntary; however NRH cannot honor my request to release information or records without a signed authorization. See 45 CFR 164.514 (b)(1). My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. Records within the scope of this authorization (check marked above) may be disclosed pursuant to this authorization. Subsequent records will not be automatically released. If subsequent records within the scope of this authorization are requested, the patient or recipient is responsible for notifying NRH of such request. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it, if requested.			
<b>Section B: The request of PHI is for the purpose of marketing</b>			
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____			
<b>Section C: Signatures</b>			
I have read the above and authorize the disclosure of the protected health information as stated.			
_____ <b>Signature of Patient/Patient Representative</b>		_____ <b>Date</b> (Auth. expires 6 months from this date)	
If you prefer this authorization to expire before 6 months from today – list expire date here: _____			
_____ <b>Print Name of Patient's Representative</b>		_____ <b>Relationship to Patient</b>	
Internal Use:			
<b>Witness Signature:</b>	<b>Date Copied:</b>	<b>Date Logged:</b>	<b>Date Released:</b>
<b>Specific Records Released:</b>	<b>Type of ID:</b>	<b>Copied by:</b>	<b># Pages:</b>

