Phelps Memorial Health Center
1215 Tibbals St, Holdrege, NE 68949
308-995-2211 - Fax 308-995-3333

Release completed by:_____

DATE: _____ MR #: _____

REQUEST FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone #: _____ **Release effective until the end of this year** _____

Release Records From:

Phelps Memorial Health Center (Hospital)
Phelps Medical Group (Clinic)
Phelps Memorial Specialty Clinic

For the purpose of:

Transferring Care to Another Provider
Continuation of Care
Personal Reasons

Release Records To:

Patient
Provider/Hospital (Provide address information)
Other Person (Provide address information)

Name: _____

Address: _____

City/State/ZIP: _____

Fax#: _____

Email: _____

☐ I would like to **INSPECT** my health record. I understand an employee of PMHC will be present during this time and that I may not make marks in or alter the record in any way.

***INFORMATION TO BE RELEASED:**

Dates of Service: _____ **COMPLETE HEALTH RECORD** (Includes all reports below as available)

☐ History & Physical ☐ D/C Summary ☐ Consultation ☐ Progress Notes ☐ ER Note

☐ Lab Results ☐ Imaging Reports: _____ ☐ Other:_____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information compiled in reasonable participation of, or for use in a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

I understand that I can revoke this authorization at any time by giving written notice to PMHC. My revocation will not be effective to the extent action has already been taken and the information was released in response to this authorization.

I understand that I am under no obligation to sign this form and that Phelps Memorial Health Center may not condition treatment on my decision to sign this authorization, subject to the following exception: If my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, then Phelps Memorial Health Center may refuse to treat me if I do not sign this authorization. (HIPAA 164.508)

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

*I understand that PMHC will charge me a reasonable fee of $0.25 per page after the first 10 pages, and $10.00 for records transferred to a compact disc.

PATIENT SIGNATURE: _____ **DATE:**_____

If not signed by the patient, please indicate your relationship:

☐ **Parent of minor child** (by checking this box I certify there is not a court order denying me access to my child's record)
☐ **Guardian of minor or incompetent patient** as pursuant to HIPAA 164.502(4) – Please provide proper documents.
☐ **Power of Attorney** of named patient above (must provide documents)
☐ **Personal Representative of a deceased patient** as pursuant to HIPAA 164.502(4) – Please provide proper documents.
☐ **OTHER** (specify and provide documents if needed):_____

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-308-995-2211.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-308-995-2211.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-308-995-2211.

العربية (Arabic)*

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-308-995-2211 .

unD (Karen)

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-308-995-2211.

Français (French)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-308-995-2211.

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-308-995-2211.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-308-995-2211.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-308-995-2211.

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-308-995-2211. ।

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-308-995-2211.

ພາສາລາວ (Laotian)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສັ້ງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-308-995-2211.

کوردی (Kurdish)

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 308-995-2211 .

فارسی (Farsi/Persian)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-308-995-2211.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-308-995-2211.