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

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) (FAX: 308.995.4868)
  1315 Tibbals Street, Holdrege, NE 68949
- ☐ 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#: _____

☐ 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):_____

Phelps Memorial Health Center FAX: 308-995-3333 **Phelps Medical Group FAX: 308-995-4868**