

**Authorization for Release of Health Information**

**Patient Name** **D.O.B.**

**Address** **Phone #**

**REQUEST INFORMATION FROM:**

\_\_\_\_ Great Plains Health

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclose to**:

Recipient name Address Phone Number

**Purpose(s) of Disclosure**:

**Information to be Disclosed:**

|  |  |
| --- | --- |
| \_\_ History and physical examination | \_\_ Emergency room record |
| \_\_ Progress notes | | \_\_ Discharge report |
| \_\_ Lab reports | | \_\_ After care plan |
| \_\_ X-ray reports | | \_\_ Financial record |
| \_\_ Consultation report | | \_\_ Complete 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) |

**Dates of Service or Time Period of Records to be Disclosed**:

(State time period or “all”)

***I understand and acknowledge that***:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at GPHealth.

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 one year (365 days) after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice. 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) this document and have received a copy if requested.

5. I acknowledge there may be a charge for this service.

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

Send original to HIM, scan a copy to the Authorization for Release of Information folder in D700Home

\*RELEASE\*

Release of Information (PHI) PH (308) 696-7440 FX (308) 696-7396