Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Request records from:

Name (Provider or Location): _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

Release records to:

Name (Provider or Location): _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Phone: _____

or

☐ **Health Information Management, 1600 S. 48th St., Lincoln, NE 68506 or Fax to 402-481-1035**

Purpose for request: ____Insurance ____Personal ____Employment ____Transfer of Care ____Continuity of Care

Other _____

Information to be shared:

Dates of Service (specific dates) From: _____ To: _____

____**Complete Record** ____Radiology Film/Media ____Radiology Reports ____ER Record ____Lab/Path Reports

____Immunization Record ____Financial Record ____Discharge Summary ____Operative/Procedure Report

____History and Physical ____Office/Clerical Notes ____Specialty Clinic Record ____Chemical Dependency Evaluation Assessment

____Other _____

I understand the information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ___No ___Yes Date: _____

Mental Health Records ___No ___Yes Date: _____

Disclosure Format _____Mail _____Fax _____USB _____CD ____Encrypted Email

_____ Unsecured Email (I understand information in this format is at risk for unintentional access by a third party)

Unless otherwise revoked, this authorization expires on the following date/event/condition: _____

By completing this authorization, I agree I have read and understand the definitions outlined on the reverse side of this form:

_____ _____ _____

Patient or Legal Representative Signature Date Time

_____ _____

Print Name Relationship to Patient (if applicable)

_____

Witness Signature for Patient Unable to Sign

Bryan Health

PATIENT REQUEST TO OBTAIN HEALTH INFORMATION FROM ANOTHER FACILITY

Place Patient Label Here

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Release of Information Department at the facility at which the request was made. Revocation will not apply to information that has already been disclosed in response to this authorization.

- If I fail to specify an expiration date/event/condition, this authorization expires one year from the date signed.

- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

- This information has been disclosed to you from records which may be protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

- Treatment, payment, enrollment, or eligibility for benefits may not be conditional on whether I sign this authorization.

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.