West Holt Memorial Hospital

406 W. NEELY ST. ATKINSON, NE 68713
TELEPHONE 402 925-2811 FAX 402 925-2580

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME _____ **D.O.B.** _____

ADDRESS _____ **PHONE #** _____ **MR #** _____

I hereby authorize* West Holt Memorial Hospital/West Holt Medical Clinic *to use and/or disclose my health information as follows:

DISCLOSE TO:_____
Recipient name Address Fax Number/Encrypted Email

PURPOSE(S) OF DISCLOSURE:

☐ Check this box if disclosure is at the request of the individual.

☐ If the purpose for the disclosure is marketing, check this box only if West Holt Memorial Hospital/West Holt Medical Clinic *will* receive direct or indirect remuneration from a third party.

INFORMATION TO BE DISCLOSED:

☐ History and physical examination	☐ Emergency room record
☐ Progress notes	☐ Discharge summary
☐ Lab reports	☐ Operative report
☐ X-ray reports/CT/Ultrasound/MRI/Mammography/Echocardiogram ☐ Computerized Disk, if available	☐ Pulmonary function tests/Polysomnography/Oximetry
☐ Consultation report/Outreach Clinic	☐ Cardiac/Pulmonary Rehabilitation
☐ EKG/Treadmill/Rhythm strips/Holter/Stress Test	☐ Financial record
☐ Physical/Occupational/Speech Therapy	☐ Complete record/ALL
☐ Clinic Office Visit	☐ Other:

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 West Holt Memorial Hospital/West Holt Medical Clinic.

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 _____ months (maximum time 12 months) 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) and have received a copy of this document.

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

Records Released by (please initial) _____ Records need to be completed by HIM Dept _____