

## Authorization for Release of Health Information

### INSTRUCTIONS:

- Sections 1-5 must be completed. If any section is not complete or section 5 unsigned, this authorization will be considered incomplete and not valid.
- Please print legibly.
- Refer to NMC Notice of Privacy Practices for additional information.

### SECTION 1 - Demographic

Print Patient's Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Other Names Used: \_\_\_\_\_ Social Security Number : \_\_\_\_\_  
 Patient Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Telephone Number: Home \_\_\_\_\_ Work \_\_\_\_\_ Fax \_\_\_\_\_

### SECTION 2 – Identification of Party Authorized to Release and Party Authorized to Receive Protected Health Information

Information Requested From: \_\_\_\_\_  
 \_\_\_\_\_  
 Release Information To: \_\_\_\_\_  
 \_\_\_\_\_

### SECTION 3 –Purpose

Purpose for Release: \_\_\_\_\_

### SECTION 4 – Type of Access Request

Copy of record  Inspection of Record

Treatment date(s): \_\_\_\_\_

\*Check box A B or C. If you want each type of record/ information disclosed, you must use three separate forms.

<p>The information to be released is:</p> <p><input type="checkbox"/> <b>A. Medical records excluding Psychotherapy notes and Generations records:</b></p> <p><b>Including:</b></p> <p><input type="checkbox"/> Discharge Summary  <input type="checkbox"/> Billing Records  <input type="checkbox"/> Consult Reports  <input type="checkbox"/> History/Physical  <input type="checkbox"/> Radiology/Imaging  <input type="checkbox"/> Emergency Department Records</p>	<p><input type="checkbox"/> Laboratory Records  <input type="checkbox"/> Operative Reports  <input type="checkbox"/> Physical/Speech/ Occupational Therapy Records  <input type="checkbox"/> Prenatal records  <input type="checkbox"/> Other _____  <input type="checkbox"/> Entire Record (Excluding Psychotherapy and Generations)</p>	<p><input type="checkbox"/> <b>B. Psychotherapy notes only</b></p> <p>Note: Psychotherapy notes may not be provided without patient authorization and prior approval of the Generations Medical Director.</p> <p><b>Approved:</b> _____          _____ [ ] Yes          Initials [ ] No</p>	<p><input type="checkbox"/> <b>C. Generations records only</b></p> <p>Note: Generations medical record may not be released without prior approval of Generations Medical Director.</p> <p><b>Approved:</b> _____ [ ] Yes          _____ [ ] No          Initials</p>
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### SECTION 5 –Statements of Understanding

- I understand that once my health information has been released, it will no longer be subject to federal privacy regulations and may be released by the person receiving it.
- I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another person.
- I understand that I may see and copy the information described on this form as provided by federal regulations, and that I will get a copy of this form after I sign it.
- Specify the date, event or condition upon which this authorization expires: \_\_\_\_\_  
 (If left blank, expiration date is one year after the day entered below)
- I understand that I can revoke this authorization in writing but that any revocation is not effective for releases that have already been made. To revoke this authorization, I should contact:

**Privacy Officer 1-316-804-6178 or Patient Access 1-316-804-6051 or Health Information Mgmt 1-316-804-6030**

Signature of Patient or Patient's Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Relationship to Patient: \_\_\_\_\_

Printed Name of Personal Representative: \_\_\_\_\_

Address & telephone number of Personal Representative: \_\_\_\_\_

## Authorization for Release of Health Information – HIM

## Authorization for Release of Health Information

TO BE COMPLETED BY HEALTH INFORMATION MANAGEMENT

Approval by Privacy Officer for Non-Treatment Payment Operations requests: Yes \_\_\_ No \_\_\_ Initial \_\_\_ NA \_\_\_ Date \_\_\_\_\_

Identification verified by: \_\_\_\_\_ Date: \_\_\_\_\_

Information sent by: \_\_\_\_\_ Number of Copies: \_\_\_\_\_ Date Copies Sent: \_\_\_\_\_

MRUN: \_\_\_\_\_ Date Received in HIM: \_\_\_\_\_ White: Medical Record Yellow: Patient

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