AUTHORIZATION TO REQUEST AND RECEIVE PROTECTED HEALTH INFORMATION

STAT:_____ 1st Request:_____ 2nd Request:_____ 3rd Request:_____

To be completed by JCHL staff

RE: Patient Name: _____ Date of Birth: _____/_____/_____

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

☐ **Clinic Office**	☐ **Hospital HIS**	☐ **Gardenside**	☐ **Other:**
Fax: 402 729 4010	**Fax: 402 729 2102**	**Fax: 402 729 3391**	**Fax:**
Phone:402 729 3361	Phone: 402 429 3351	Phone: 402 729 5220	**Phone:**

Jefferson Community Health and Life, 2200 H Street, Fairbury, NE 68352

Records are requested by the above and may be provided by fax or mail. Please include this form.

The following are requested:

[ ] Abstract-Recent H&P/ office visit with current med list, discharge summary, last 12 months of labs

[ ] All Laboratory Reports [ ]All Radiology Report(s) [ ]All Immunization Record(s)

[ ] Itemized billing records [ ]Complete record

[ ] Other: _____

Purpose for requesting information: [ ]Continuation of Care [ ]Legal [ ]Insurance [ ]Other:_____

Provider or staff member requiring records: _____

☐ **Records have been received and routed to provider/staff member Date:_____ Initials:_____**

To be completed by patient or legal responsible party

Records to be released from:

_____

Facility or Provider Name Address Fax Number Phone Number

_____

Facility or Provider Name Address Fax Number Phone Number

I HEREBY AUTHORIZE Jefferson Community Health and Life, 2200 H Street, Fairbury, NE 68352 to request and receive the records indicated and understand the following**:**

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Information in the health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include behavioral, mental health, alcohol or drug abuse records.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Services at the following address: 2200 H Street, Fairbury, NE 68352 Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless revoked, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries potential for unauthorized re-disclosure, the information may not be protected by federal rules.
- Marketing: Financial remuneration has been received by a third party for marketing purposes. (Required if applicable to the organization) Sale of PHI: Remuneration is received for disclosure of my health information. (Required if applicable to the organization)

State and Federal Law protect the following information. Please indicate if you want this information released/obtained.

Alcohol, Drug, or Substance Abuse Records [ ] Yes [ ] No Dates:_____

HIV Testing and Results [ ] Yes [ ] No Dates:_____

Mental Health or Psychotherapy Records. [ ] Yes [ ] No Dates:_____

_____ _____

Printed Name of Signer Relationship to Patient

_____ _____

Patient or Responsibility Party Signature Date