Memorial COMMUNITY HEALTH

dba Memorial Health Clinics (Aurora, Clay Center), Memorial Hospital, Memorial Community Care, East Park Villa

REQUEST FOR ACCESS TO OR RELEASE OF PROTECTED HEALTH INFORMATION

PT MRN: _____

INSTRUCTIONS: ***Please complete this form*** *to request an inspection or copies of your health information. There are certain circumstances in which your request may be denied. If so, you will be notified of the reasons why. You will be notified of any fees that may apply ($ 0.50 per pg., but no more than $20) §71-8404. Please allow a minimum of 72 hours after the written requests and up to 7-10 business days for all sent mailed requests. Individuals generally have access to their medical records during and after treatment via the Patient Portal. All medical records sent for continuity of care are complimentary. Encrypted emails are sent unless the recipient requests unencrypted.*

PATIENT NAME: _____DOB: _____
ADDRESS: _____
PHONE NUMBER: _____ Email: _____

DATE(S) OF SERVICE REQUESTED: _____

PLEASE CHECK BELOW THE INFORMATION, WHICH YOU WOULD LIKE RELEASED:

- ☐ **Clinic visit notes**
- ☐ **Consultation report**
- ☐ **History & Physical exam**
- ☐ **Emergency room exam**
- ☐ **X-ray reports**
- ☐ **Radiology images**
- ☐ **Lab reports**
- ☐ **Discharge summary**
- ☐ **Financial record**
- ☐ **Other_____**

I specifically authorize the release of information pertaining to:

☐ **Substance abuse** ☐ **Mental Health** ☐ **HIV/AIDS (including test results)**

PROHIBITION ON REDISCLOSURE OF DIAGNOSIS, TESTING AND/OR TREATMENT OF: *Alcohol use, Drug use, HIV, sexually transmitted disease, Psychiatric disorders and/or mental health information. This information has been disclosed from records protected by federal law. 42CFR Part 2 prohibits any further disclosures of these records without a specific written authorization of the person to whom it pertains, or as otherwise permitted by law.*

Purpose of Disclosure: __ Personal Records __Transfer of Care __ Other

☐ **I authorize Memorial Community Health, Inc. (MCHI) to release or obtain records from:**

TO: _____ **FROM:**_____
_____ _____

PLEASE INDICATE THE METHOD OF RELEASE:

- ☐ Will pick up
- ☐ Fax to: _____
- ☐ Unencrypted Email: _____

I Understand that: Memorial Community Health, Inc. entity is not liable after any medical information is disclosed and is no longer protected by federal Privacy law known as HIPAA (§45-164). Records about substance disorders will continue to be protected under federal rules following disclosure and cannot be re-disclosed without my written consent unless otherwise provided for the relevant rule §42 CFR part 2. I may revoke (cancel) this authorization at any time by notifying MCHI, Medical records department, in writing. If not revoked, this Authorization will expire in 12 months from the date I signed this form, purpose of disclosure has been met, or a date is specified on the Date of service section noted on this form. This authorization is NOT VALID unless COMPLETED in FULL. I understand that my refusal to sign will not affect my ability to obtain treatment at MCHI. I understand and accept the terms of this Authorization. A copy of this Authorization is valid as the original, I have the right to receive a copy of the signed Authorization.

_____ _____ _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE RELATIONSHIP TO PATIENT

WE WILL NOT PROCESS THIS REQUEST UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE.

OFFICE USE ONLY: Date sent: _____ Initials: _____ ☐ Copy given