Gage County Medical Clinic

A Beatrice Community Hospital and Health Center Physician Clinic

AUTHORIZATION FOR RELEASE OF INFORMATION

Mailing Address: **1101 North 10th**
Beatrice, NE 68310

Phone (402) 228-3436
Fax (402) 223-4515

Instructions:

Please complete this entire form to request inspection or copies of your personal health information. We will notify you when your request has been processed and the records are ready for inspection or have been copied and the fee for your request. There are certain circumstances in which your request may be denied. If your request has been denied, you will be notified of the denial and the reasons why. Your request cannot be processed if this form is not complete.

1. **Patient Name** ______________________________ **Birth date** ______________

   Address ______________________________ **Daytime Telephone** ______________

   ______________________________ **MRN** ______________

   Please indicate previous names used ______________________________

2. **I hereby authorize and request release of my medical records:**

   FROM: **Gage County Medical Clinic**

   TO: ______________________________
   (Name of institution or individual to receive information)

   ____
   (Street Address)

   ____
   (City) **(State)** **(Zip)**

3. **Information to be disclosed:**
   From (date) ______________ **to (date)** ______________

   - ☐ **Clinic Notes**
   - ☐ **Radiology Images**
   - ☐ **History and Physical Examination**
   - ☐ **Operative Report**
   - ☐ **Pathology Report**
   - ☐ **Laboratory Results**
   - ☐ **All records**
   - ☐ **Billing record**
   - ☐ **Other (Please specify)** ______________________________
   - ☐ **EKG/EEG Reports**
   - ☐ **Prenatal (Pregnancy) Record**
   - ☐ **Imaging Reports**
   - ☐ **Drug and Alcohol**
   - ☐ **Psychiatric/Mental Health**
   - ☐ **STD's (Sexually Transmitted Disease)**
   - ☐ **HIV (AIDS)**

4. **Purpose of release:** ☐ **Medical Care** ☐ **Transferring Care** ☐ **Personal Records** (charge may apply) ☐ **Attorney/Legal Investigation** ☐ **Application for Insurance** ☐ **Social Security Disability** ☐ **Insurance Payment**
   ☐ **Other** ______________________________

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5. **Please designate the method of review:**
   - ☐ **Mail**
     I understand that I will be charged a per page copying fee of $.50 per page for greater than 10 pages.
   - ☐ **Pick up copy of records from Gage County Medical Clinic.**
     I understand that I may be charged a per page copying fee of $.50 per page for greater than 10 pages.
   - ☐ **Inspection only**
     Inspection will be available during normal business hours
   - ☐ **Inspection and copy**
     Inspection will be available during normal business hours. I understand I may be charged a copying fee of $.50 per page for greater than 10 pages.
   - ☐ **Verbal**
     Authorizes Gage County Medical Clinic to exchange with the individual or facility named above the information specified in this authorization form.

6. **This statement of consent can be revoked at any time before disclosure of the information, and expires on __________ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, than the authorization expires 365 days after it is signed.**

   I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

   I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

______________________________	______________________________
(Signature of patient)	**(Signature of parent, guardian, or Authorized representative)**
______________________________	______________________________
(Date)	**(Relationship of above person to patient)**

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