906 W. 7th St.
P.O. Box 665
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Heartland Family Medicine
An Affiliate of Harlan County Health System

811 Howell Street
P.O. Box 425
Oxford, Nebraska 68967-0425
Ph 308.824.3288
Fx 308.824.3239

Authorization for Release of Information

Please include a photo ID with request

1. Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
(Street, City, State, Zip)

2. I hereby authorize and request release of my medical records:
From: _____ _____
(Health care facility to send information) (Address: Street, City, State, Zip)
_____ _____
(Phone Number) (Fax Number)
To: _____
(Name of entity or individual to receive information)
_____ _____
(Phone Number) (Fax Number)
_____
(Address: Street, City, State, Zip)

3. Date(s) of Service to be disclosed: _____
(Month, Date, Year)
Delivery Method of Records: ☐ Mail ☐ Fax ☐ Pick-up ☐ Electronic Copy _____
Format: (e.g. PDF, CCDA, image, picture etc.) _____ (E-mail address)

4. Purpose of Disclosure: ☐ Transfer of Care ☐ Treatment ☐ Insurance ☐ Legal Proceedings ☐ Other _____

5. Information Requested: ☐ Other _____

☐ Entire Medical Record	☐ Medication Record	☐ Immunization
☐ History & Physical	☐ Lab/Pathology Report	☐ Procedure Report
☐ Progress Notes	☐ Financial Record	☐ Radiology Report
☐ EKG/ECG Report		

6. I understand that my health information may contain information relating to: HIV/AIDS, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law. I authorize the release of information relating to:
☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS

7. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be re-disclosed by the person receiving it. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time, in writing, prior to expiration. I understand my refusal to sign this form will not affect my ability to obtain treatment. I understand that I may view and copy the information described on this form as provided by federal privacy regulations and that I will receive a copy of this form after I sign it.

_____ _____
Patient Signature or Patient's Representative Signature Date

_____ _____
Representatives Printed Name Relationship to Patient

_____ _____
Prepared By Date