Harlan County Health System
717 North Brown,
P.O. Box 836 Alma, NE 68920-0836
Phone (308)928-2151
Fax (308)928-2118

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: ☐ Treatment ☐ Insurance ☐ Legal Proceedings ☐ Other _____

5. Information Requested: ☐ Other _____

☐ Entire Medical Record	☐ Medication Record	☐ ER Record
☐ History & Physical	☐ Lab/Pathology Report	☐ Procedure Report
☐ Discharge Summary	☐ Radiology Report	☐ Financial Record
☐ Progress Notes	☐ EKG/ECG Result	Therapy: ☐PT ☐ OT ☐ ST

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