KEARNEY REGIONAL Medical Center

Release of Patient Protected Health Information

Kearney Regional Medical Center and **Platte Valley Medical Clinic**
804 22nd Avenue Kearney, NE 68845

Return Request To
HIM Fax: (308) 865-2541 **OR** medrecreleases@kearneyregional.com

Patient Full Name: _____ **Patient Date of Birth:** _____

Patient Full Address: _____ **Patient Phone # :** _____

I hereby authorize ***Kearney Regional Medical Center and/or Platte Valley Medical Clinic*** to use or disclose my health information as follows:

OBTAIN FROM: _____ _____
Name — Address **OR** Fax Number

DISCLOSE TO: _____ _____
Name — Address **OR** Fax Number

Purpose(s) of Disclosure: _____

Method of Disclosure for Self Request: ☐ **Mail to address above** ☐ **Email:** _____ ☐ **Fax:** _____

Date Range of Services to Disclose:

From _____ To _____
Month/Year — Month/Year

Data/ Information Requested

- ☐ Provider Notes
- ☐ Laboratory Results
- ☐ Consults
- ☐ Radiological/Diagnostic Test
- ☐ Surgical/Procedure Notes
- ☐ Complete Chart
- ☐ Imaging Disk for Diagnostic Tests
- ☐ Medication List/Immunizations
- ☐ Bryan Health Complete Record **Request will be sent to Lincoln**
- ☐ Other: _____

I specifically authorize the release of information relating to: (Check if applicable)

- ☐ Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) infection
- ☐ Behavioral Health / Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse

Conditions:

- The patient understands that his/her healthcare information is to be used for treatment, payment or for health care operations.
- The patient understands that his/her healthcare information may be disclosed to other healthcare providers for the purpose of treatment, payment or for healthcare operations.
- The healthcare organization reserves the right to either honor or dismiss the patient's request to limit the use of the patient's healthcare information.
- This consent can be revoked; however, the request must be in writing.
- Additional information can be obtained by reading the organization's Privacy Notice.
- This consent form will be maintained by this organization for a period of six (6) years.

_____ _____ _____
Signature of Patient or Patient Personal Representative — Date — Legal Representative/Relationship to Patient

Processed By: _____

k.roi