KEARNEY REGIONAL
Medical Center

HIPAA RELEASE FORM

I have reviewed the Notice of Privacy Practices and Patient Rights forms. I hereby acknowledge that I have read and understand the content within, and realize I may request my own copy of these documents at any time.

I hereby authorize Kearney Regional Medical Center to provide any portion of my medical record as requested, unless otherwise specified. Additionally, my medical condition may also be discussed with these individuals

☐ No changes from previous consent
☐ Opt out of records release

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

CONDITIONS:

- This form will be maintained by this organization for a period of six (6) years.
- I understand that my healthcare information may be disclosed for the purposes of treatment, payment or for healthcare operations.
- This healthcare organization reserves the right to either honor or dismiss my request to limit the use of the 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.

Name of Patient (Print) _____ Date of Birth _____

Patient or Representative Signature _____ Date/Time _____

Relationship or Representative to Patient _____

Hospital: 804 22nd Ave Kearney, NE 68845
Hospital Main: (308) 455-3600
Hospital Fax: (308) 455-3950

Clinic: 816 22nd Ave Ste.100 Kearney, NE 68845
Clinic: 3712 28th Ave Kearney, NE 68845
Clinic Main: (308) 865-2263
Clinic Fax: (308) 865-2541

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