Great Plains
Regional Medical Center

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME_____ **D.O.B.**_____

ADDRESS_____ **PHONE #**_____

REQUEST INFORMATION FROM:

___ Great Plains Regional Medical Center

___ Other _____

DISCLOSE TO:_____
Recipient name Address Phone Number

PURPOSE(S) OF DISCLOSURE:_____

INFORMATION TO BE DISCLOSED:

__ History and physical examination	__ Emergency room record
__ Progress notes	__ Discharge report
__ Lab reports	__ After care plan
__ X-ray reports	__ Financial record
__ Consultation report	__ Complete record

I specifically authorize the release of information relating to:

__ Substance abuse (including alcohol/drug abuse)
__ Mental health
__ HIV/AIDS related information (including test results)

DATES OF SERVICE OR TIME PERIOD OF RECORDS TO BE DISCLOSED:_____
(State time period or "all")

I understand and acknowledge that:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at GPRMC.

2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.

3. This authorization is effective for 180 days after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.

4. I have read (or had read to me) this document and have received a copy if requested.

5. I acknowledge there may be a charge for this service.

A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____
Signature of patient or patient's personal representative Date

_____
Relationship to patient if signed by personal representative