Kimball Health Services

A fee for copying medical records may be assessed to the requestor.
Please check with the medical records clerk

AUTHORIZATION FOR DISCLOSURE **OF MEDICAL RECORD INFORMATION**

PATIENT NAME:_____DOB:_____MR#: _____
ADDRESS:_____

RELEASE INFORMATION FROM: ☐ Kimball Health Services Hospital Records ☐ Kimball Health Services Clinic Records
☐ Pine Bluffs Clinic
☐ Other (specify): _____

RELEASE INFORMATION TO: ☐ Kimball Health Services Hospital Records ☐ Kimball Health Services Clinic Records
☐ Pine Bluffs Clinic
☐ Other (specify): _____
Dates covered: _____

PLEASE SPECIFY TYPE OF INFORMATION TO BE RELEASED:

_____History & Physical	_____Discharge Summary	_____Operative Notes
_____Consultations	_____Emergency Room Report	_____Progress Notes
_____Dismissal Instructions	_____Radiology Reports	_____Social History
_____Lab Results	_____Home Health	_____Other (specify): _____

PURPOSE FOR WHICH INFORMATION IS TO BE USED:
☐ Treatment ☐ Insurance ☐Personal ☐ Follow-up ☐ Legal Proceedings ☐ Other (specify): _____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. If this authorization applies to treatment for any of the following condition(s), please initial:
____ Chemical Dependency or Abuse ____ Alcoholism or Alcohol Abuse ____ Infection with Human Immunodeficiency Virus (HIV)
____ Sickle Cell Anemia ____ Mental Health Records

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Written revocation shall be submitted to the Privacy Officer or designee.

- This authorization will automatically expire 180 days from date of signature.
- Information disclosed may be subject to redisclosure by the recipient and no longer be protected by state or federal law or regulations.
- Any photostatic of this authorization shall be as effective as any original signed by me.
- I will not be prohibited any future benefits, including treatment, payment or eligibility thereof from said provider by refusing to sign this authorization

SIGNATURES:
Patient &/or Representative: _____ Date: _____
If other than patient indicate relationship: ☐ parent ☐ spouse ☐ guardian/personal representative☐ Other (specify):
Witness:_____ Date:_____

Released by_____Date_____Pages_____

A photocopy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

Mail to: Kimball Health Services
224 W 4th St.
Kimball, NE 69145

Phone: (308) 235 - 1952
Fax: (308) 235 - 1955