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| --- | --- | --- | --- | --- | --- | --- | --- |
| **P:\Logo\fwdhospitallogos\niobrara bw logo\niobrara bw logo\niobrara-community-hospital-logo-bw.jpgP:\Logo\fwdhospitallogos\rawhide bw logo_wEmboss\rawhide-rural-health-clinic-logo-bw.jpg**  **Niobrara Community Hospital**  **Rawhide Rural Health Clinic**  Authorization to release Health Care Information | | | Health Information Management  Niobrara Community Hospital/Rawhide Rural Health Clinic  921 S Ballancee Ave Lusk, WY 82225  Fax (307) 334-2712. Phone (307) 334-4000 ext. 255 | | | | |
| **(1) Patient** | Legal Name: | | | Preferred/Previous Name(s): | | | |
| Birth Date: | | | Phone Number: | | | |
| Address: | | | City: State: Zip: | | | |
| **(2) Information**  **Released**  **FROM** | Niobrara Community Hospital  Other Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Rawhide Rural Health Clinic Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **(3) Dates of service** **(required)** | Dates of Service : **FROM**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TO**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **(4)Information disclosed TO** | Individual/Facility/Organization OR SELF: | | | | | | |
| Attn/Dept: | | | | Phone Number: | | Fax: |
| Address: | | | | City: | State: | Zip code: |
| **(5) Health Information to be Released** | Abstract Record  (most commonly requested  **Check for specialty items**  Radiology images (CD)  Billing Information  Other (specify below): | ***Check if only need individual reports***  Provider dictation/notes  MD Notes  ER/Urgent Care Record  History & Physical  Consults  Operative/Procedure reports  Discharge summary  \_\_\_\_\_\_\_\_\_\_\_\_\_  Other (specify below): | | | ***Check only if need individual reports***  Diagnostics  EKG/Tracings  LAB(s)/Pathology reports  Radiology reports  Miscellaneous  Immunizations  Medications  Complete record | | |
| **(6) Sensitive information** | **By initialing, I authorize release of the following sensitive information:**  \_\_\_\_Alcohol/drug testing \_\_\_\_HIV/AIDS test results or diagnoses  These items will not be released unless initialed. | | | | | | |
| **(7) Purpose of disclosure** | \_\_\_Personal \_\_\_Continuity of care \_\_\_Worker’s Comp \_\_\_Insurance \_\_Disability  \_\_\_ Legal \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  There may be a charge/fee for copies of records. | | | | | | |
| **(8) Delivery Method** | Information to be released on : \_\_ MyPortal (**NCHD** providers **only**) \_\_\_\_Paper Information needed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Send by: \_\_\_FAX \_\_\_ MAIL \_\_\_\_ PICK UP by patient or *Designee\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  \_\_\_Email: preferred email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_Encrypted  **Staff** initial\_\_\_\_\_\_\_\_ | | | | | | |
| **(9) Authorization** | **I hereby authorize Niobrara County Hospital district to release the health information indicated above to the recipient named.**  1. I may revoke this authorization at any time in writing, but if I do, it will not have any impact on any actions taken prior to receiving the revocation  2. I understand fee for copy service may apply  3. Your health care (or payment for care) will not be affected by whether or not you sign this authorization.  4. Information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. | | | | | | |

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**Patient’s/Patient Representative’s Signature Print Name of signee Date**

***(If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.)***

\_\_\_Parent \_\_POA \_\_\_Guardian \_\_other This authorization will expire one year from signature date unless otherwise stated: \_\_\_\_\_\_\_\_\_\_\_\_