Franciscan Healthcare
Your health is our passion.

430 N. Monitor Street
West Point, NE 68788-1595
franhealth.org

CLINIC
Phone **402.372.4044** *Fax* **402.372.6770**

HOSPITAL
Phone **402.372.6724** *Fax* **402.372.6768**

Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Previous/Maiden Name: _____

I authorize the disclosure/release of my information (Request must have **complete** addresses):

☐ To Franciscan Healthcare
☐ From 430 N. Monitor Street
West Point, NE 68788
Clinic Fax 402.372.6770
Hospital Fax 402.372.6768

☐ To Name _____
☐ From
Address _____
City/State/Zip _____
Phone & Fax _____ / _____

DATE(S) OF SERVICE REQUESTED: From _____ (date) to _____ (date).

PLEASE NOTE: If dates are not provided, only the past year will be sent.

INFORMATION TO BE DISCLOSED:	
☐ History and Physical Examination	☐ Financial Record
☐ Progress Notes	☐ Substance Use Disorder Records ☐ All ☐ Only the following substance use disorder records: _____ _____
☐ Lab Reports	
☐ Radiology Reports	
☐ Consultation Report	
☐ Emergency Room Record	☐ Complete Record
☐ Discharge Report	☐ Other _____

I SPECIFICALLY AUTHORIZE THE RELEASE OF INFORMATION RELATING TO:

☐ HIV/AIDS related information (including test results) ☐ Mental Health ☐ Genetic Testing Results

THE PURPOSE OF RELEASING OR OBTAINING THE ABOVE INFORMATION:

☐ Transfer of Care ☐ Continuity of Care ☐ Insurance/Billing ☐ Legal ☐ Personal ☐ Other _____

DISCLOSURE FORMAT AND DELIVERY METHOD:

☐ Encrypted Email ☐ Mail ☐ Pick Up ☐ Fax ☐ Other _____

By signing this form, I understand that I have the right to revoke this authorization at any time, except where an affiliate of Franciscan Healthcare has already acted in reliance on your authorization. Revocation must be made in writing to the health information management department at Franciscan Healthcare, Attention: HIM Department, 430 North Monitor Street, West Point, NE 68788.

I understand and acknowledge that:

- My refusal to sign this authorization will not affect my ability to obtain treatment.
- Medical information to be disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by state or federal law.
- This authorization is effective for 12 months after the date it was signed unless otherwise specified. I understand that I may revoke this authorization at any time by giving written notice to HIM. My revocation will be effective to the extent action has already been taken in reliance on my authorization.

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 | Time

_____ _____
Relationship to patient if signed by personal representative | Witness

THIS REQUEST WILL NOT BE PROCESSED UNLESS IT IS SIGNED BY YOU OR YOUR REPRESENTATIVE.