Patient Name: _____ Date of Birth: _____

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

Email Address: _____ Phone: _____

I request that my protected health information (PHI) from

____Bryan Heart ____Bryan Medical Center ____Bryan Physician Network ____Crete Area Medical Center

____Crete Medical Clinic ____Friend Medical Clinic ____Wilber Medical Clinic

____Other (specify) _____

be disclosed to:

Recipient Name: _____ Fax: _____

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

Email Address: _____ Phone: _____

I authorize the following PHI to be released from my medical record: ____ER Record ___Lab Reports ____Radiology Reports
____Immunization Record ____Complete Medical Record (all pages) ____Radiology film/imaging studies/tracings/media
____Financial Record ____Discharge Instructions ____Chemical Dependency Evaluation Assessment ____Office/Clinical Notes
____Specialty Clinic Record _____Abstract Summary (includes Discharge Summary, History & Physical, Operative Reports, Consultations and Test Results)

Covering the period of healthcare from (specific dates) _____ to _____ OR
____All past, present, and future visits relating to the event specified here _____

Purpose for request: ____Legal ____Insurance ____Personal ____Treatment ____Disability ____Other _____
____Employment

I understand that the information in my health record may include information relating to sexually transmitted disease, mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ____No ____Yes Dates: _____
Mental Health Records ____No ____Yes Dates: _____

Disclosure Format (paper is default) ____Fax ____Encrypted email ____Unencrypted email (I understand the risk in receiving my PHI via unencrypted email & that it may be read by a third party) ____Upload to "MyChart" ____CD ____USB Drive (additional charge)

By completing this authorization form, I agree that I understand:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Release of Information Department at 1600 S. 48th St., Lincoln, NE 68506. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization expires on the following date/event/condition: _____ . If I fail to specify an expiration date/event/condition, this authorization expires one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules; however, Alcohol, Chemical and Drug Abuse patient records which are disclosed will be accompanied by a written statement as required by law prohibiting further disclosure except as allowed by law.

_____ _____ _____
Signature of patient or legal representative | Relationship (if not patient) | Date

_____
Name of witness to signature or verbal/non-verbal approval

_____ _____
Signature of witness | Date

Bryan Health

PATIENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Place Patient Label Here