CMH
Community Memorial Hospital
Syracuse Medical Center
Weeping Water Medical Center

P.O. Box M
Syracuse, Nebraska 68446
Phone: (402) 269-2411
Fax: (402) 269-7624

Authorization to Release Health Information

Patient Name_____ DOB _____ Phone # _____

Address_____

I authorize Community Memorial Hospital, Syracuse Medical Center, and Weeping Water Medical Center to use and/or disclose my health information as follows:

☐ *Release Health Information To*
Medical Records
PO Box M
Syracuse, NE 68446

OR

☐ *Receive Health Information From*
☐ Syracuse/Weeping Water Medical Center
☐ Community Memorial Hospital

_____
(Name Person or Place to release records to **OR** to receive records from) Phone #

_____
Address Fax #

Purpose of Disclosure: ☐ Transfer of Care ☐ Personal Record ☐ FMLA* ☐ Disability* ☐ Other_____

Information to be Disclosed:

☐ Complete Record or
☐ History & Physical exam
☐ Discharge report
☐ Progress Notes
☐ Emergency room record
☐ Radiology reports
☐ Consultation report
☐ Office/Clinic notes
☐ After care plan
☐ Immunization Record
☐ Lab reports
☐ Billing record

I specifically authorize the release of information relating to:
☐ Substance Abuse (including drug/alcohol abuse)
☐ Mental Health
☐ HIV/AIDS related information (including test results)

Date(s) of Service: _____
(State: specific dates, 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 the organization.
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 12 months after the date it was signed. I understand that I may revoke this authorization at any time by giving written notice to the organization. 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 this disclosure is at my request.
5. 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

☐ Fax ☐ Mailed ☐ Pick-Up
MR #: _____

Note: Once the office discloses health information, the person or organization that receives it may be able to disclose it. Privacy laws may no longer protect it.