MR # _______________
Acct # _______________

GORDON MEMORIAL HOSPITAL DISTRICT
300 E 8TH STREET
GORDON NE 69343
PHONE 308-282-0401 FAX 308-282-0431

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name :____Date of Birth: _____/______/_______

Address: ____ City: ___________________ State: ______ Zip: _______

E-mail Address: __________________________________ Phone: ____

I request that my protected health information (PHI) be released:

From:	**To:**
Facility Name: ___________________________________	**Recipient Name:** _________________________________
Address: ____	**Address:** _______________________________________
Phone/Fax # ______________________________________	**Phone/Fax #** ____________________________________

Covering the period of healthcare from: Specific Date(s): _____________________ to ____________________

____ The patient is currently in our facility (ER/Hospital) receiving care. Please send records ASAP to Fax #308-282-6257
Healthcare Personnel/Title: ____

The type of information to be used or disclosed is as follows: (Please check the appropriate boxes and include other information where indicated.)

_____ History & Physical	_____ Discharge Summary	_____ Lab Tests
_____ X-ray Reports	_____ Consultation Reports	_____ Radiology CD
_____ Progress Notes	_____ Operation Reports	_____ Photographs
_____ Entire Record	_____ Other ______________________________________	

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Check One: ____ Yes ____ No

- Without my specific revocation, this authorization will expire in 180 days of signature. A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient.
- Authorization: I certify that this request has been made voluntarily and that the information stated above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken to comply with it. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form.
- Re-Disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: Patient____Date: _______________

If other than the patient, indicate relationship: ___Parent ___Guardian/Legal Representative/POA

Witness: Name ____ Date: _______________

Office Use Only: This request was completed by ____________________________________ Date: ______________