Western Plains Medical Complex
RELEASE OF INFORMATION
AUTHORIZATION / REQUISITION FORM (Circle One)

Section A: *This section to be completed by the patient.*

Patient Name:		Medical Record #:	
Address:		Social Security #:	
		Date of Birth:	

RELEASING Facility	Facility Name:	
	Address:	
	City/State/Zip:	
	Phone #:	
REQUESTING Facility or Individual	Requestor Name :	
	Address:	
	City/State/Zip:	
	Phone:	

Date(s) of Service:

List specific description of information to be released:					
☐ Anesthesia	☐ Discharge Summary	☐ Imaging Reports	☐ Physician Orders	☐ All Records
☐ Billing Records	☐ EKG's	☐ Laboratory	☐ Outpatient Records	☐ Other ________
☐ UB92	☐ Emergency Records	☐ Medication Records	☐ Pathology Report	☐ ________
☐ Itemized Bills	☐ Face Sheet	☐ Nursing Records	☐ Progress Notes	☐ ________
☐ Consultation	☐ History & Physical	☐ Sgy/Proc Report	☐ Acctg of Disclosure	☐ ________

Section B: *This section to be used for providers own disclosure purposes:*

Purpose of Disclosure:

Will hospital receive financial or "in-kind" compensation for the use/disclosure of information described above?	☐ Yes	☐ No

Section C: *Must be completed by the patient for all authorizations:*

The patient or the patient's representative must read and complete information in this section:

1. I understand that the persons hereby authorized to use/disclose Information will not condition treatment or payment on my providing this authorization.
2. I understand that this authorization will expire on _____/ ______ / _______.
3. I understand that I may revoke this authorization at any time by notifying the hospital in writing, except to the extent the hospital has already taken action in reliance on the previous authorization.
4. I understand that I may see the information described on this form if I ask to see it and I understand that I will receive a copy of this form after I sign it.
5. I understand that if my records contain sensitive information that I may need to have my physician authorize the use or disclosure of it.
6. I understand that I may refuse to sign this authorization and in doing so, understand refusal to sign this authorization will not affect my treatment.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that this authorization also applies to records about me containing information about HIV, AIDS, venereal disease, or mental disorders. "In accordance with federal regulation 42 CFR part 2: I also understand that release of any and all alcohol and/or drug abuse treatment that such information cannot be released without my specific authorization, except in special circumstances. Therapists notes related to mental disorders will also require a specific authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulation, the released information may no longer be protected by federal privacy regulations. <State Specific Requirements should be entered on this line >

(Signature of Patient or Patient's representative) (Date)

(If patient representative, please print name above)

(Basis for which representative has the authority to act for the patient)

Revised March 2013