Gordon Memorial Health Services
Authorization for Use and Disclosure of Protected Health Information

Please allow a minimum of 5 business days. There may be a fee charged for copying records.

Request Records FROM:	**Request Records TO:**
□ **Gordon Memorial Health Services** □ Gordon Hospital □ Gordon Clinic □ Rushville Clinic 300 E 8th St Gordon, NE 69343 308-282-0401 (HIM 308-282-6173) FAX: 308-282-0431(hospital) 308-282-1428 (Gordon clinic) 308-327-2070 (Rushville Clinic) □ **Other** (Name/Address) _____ _____	□ **Gordon Memorial Health Services** □ Gordon Hospital □ Gordon Clinic □ Rushville Clinic 300 E 8th St Gordon, NE 69343 308-282-0401 (HIM 308-282-6173) FAX: 308-282-0431(hospital) 308-282-1428 (Gordon clinic) 308-327-2070 (Rushville Clinic) □ **Other** (Name/Address) _____ _____

Patient Name _____ **Date of Birth** _____
Address _____
Daytime phone number where we may reach you: _____

Purpose □ My Personal Records □ For Other Health Care Providers □ Insurance □ Other _____

For Dates of Service: From: _____ To: _____

□ The patient is currently in our facility (ER/Hospital) receiving care. Please send records ASAP to FAX #308-282-6257.

_____
Health Care Personnel/Title

I wish to have the following information released (please check the appropriate boxes):

□ History & Physical	□ Discharge Summary	□ Lab Tests
□ X-ray Reports	□ Consultation Reports	□ Radiology Films
□ Progress Notes	□ Operation Reports	□ Photographs/Videos

□ Other _____

I understand that information in my medical record may include information relating to behavioral health services, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), I agree to its release. Check one: □ Yes □ No

Without my specific revocation, this authorization will expire in 180 days from date 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
(circle one)
Witnessed by Name: _____ Date:_____

Office Use Only: This request was completed by _____ _ Date _____