KearneyRegional Medical Center
PLATTE VALLEY
804 22nd Ave ► Kearney, NE 68845

Clinic Main: (308) 865-2263
Clinic Fax: (308) 865-2541
Hospital Main: (308) 455-3600
Hospital Fax: (308) 455-3964

k.roi

RELEASE OF PATIENT PROTECTED HEALTH INFORMATION CONSENT & RESTRICTION AGREEMENT

☐ Hospital Records **Only** ☐ Clinic Records **Only** ☐ **Both** Hospital & Clinic

☐ **Provider Only:** _____

Please Check ONE:	**Name:** _____
☐ **Release Information To:**	**Address:** _____
☐ **Restrict Information From:**	**Fax Number:** _____

DATE RANGE OF SERVICES TO DISCLOSE OR RESTRICT

From: _____ (Month/Year) **To:** _____ (Month/Year)

Conditions:

- The patient understands that his/her healthcare information is to be used for treatment, payment or for health care operations.
- The patient understands that his/her healthcare information may be disclosed to other healthcare providers for the purpose of treatment, payment or for healthcare operations.
- The healthcare organization reserves the right to either honor or dismiss the patient's request to limit the use of the patient's healthcare information.
- This consent can be revoked; however, the request must be in writing.
- Additional information can be obtained by reading the organization's Privacy Notice.
- This consent form will be maintained by this organization for a period of six (6) years.

Data / Information Requested:

☐ Provider Notes ☐ Laboratory Results
☐ Radiology / Diagnostic Test ☐ Consults
☐ Surgical / Procedure Notes ☐ Medication List
☐ Other: _____
☐ Complete Chart: _____ Purpose: _____

I Understand That This Will Include Information Relating To: (Check if applicable)

☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection
☐ Behavioral Health Services / Psychiatric Care
☐ Treatment for alcohol and/or drug abuse

Printed Name: _____ **DOB:** _____

Signature of Patient: _____ **Date:** _____

Legal Representative / Relationship to Patient: _____