KearneyRegional Medical Center

PLATTE VALLEY Medical Group

centralplains AESTHETIC SURGERY

RELEASE OF PATIENT PROTECTED HEALTH INFORMATION CONSENT & RESTRICTION AGREEMENT

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

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

I hereby authorize: _____
Name of Provider

_____ Address | _____ City | _____ State | _____ Zip | _____ Fax

To disclose information from the medical record of:

Patient Name: _____ Last | _____ First | _____ M | _____ Date of Birth

_____ Address | _____ City | _____ State | _____ Zip

This Patient information is to be disclosed to:

Name of Provider: _____

_____ Address | _____ City | _____ State | _____ Zip | _____ Fax

Date Range of Services to Disclose or Restrict

From: _____ Month/Year To: _____ Month/Year

Data / Information Requested:

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

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

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.

_____ Signature of Patient: Date/Time _____ Legal Representative/Relationship to Patient