Newman Regional Health

Patient Authorization for Release of Protected Health Information (PHI)

1201 W. 12th Ave., Emporia, KS 66801
Ph: 620-343-6800, ext. 22625 Fax: 620-340-6767 Email: portalHIM@newmanrh.org

All Sections of this form must be completed to be valid. A photo ID will be required.

Patient Name: _____ Date of Birth: _____
Name at Time of Treatment (if different from above) _____
Address: _____ City/State: _____ Zip Code: _____
Email Address: _____ Phone: _____

I request my records FROM: Newman Regional Health / Newman Regional Health Medical Partners

□ Hospital □ Express Care □ Pediatric □ Orthopedics
□ Family Medicine □ Cardiology □ Surgical Specialists □ Newman Therapy Services
□ Other Facility: _____
Name of Doctor: _____

I request my records be: □ **SENT TO** **or** □ **PICKED UP BY myself or party listed below**
Name: _____ Email: _____
Address: _____ Phone: _____

City/State: _____ Zip: _____ Fax#: _____

Type of records needed:

□ **All Records** □ Detailed Billing
□ Emergency Room Record □ Office Visit Note(s) □ Abstract Summary
□ Laboratory Report(s) □ Operative Record □ FMLA
□ Radiology Report(s) □ Immunization(s) □ Physical/Speech/Occu. Therapy Notes
□ OB/GYN □ Well Child Check/Physical □ Images on CD/Radiology

□ Other (specify): _____

Date of Care (Note – records from 2018 to present are available on My Health Info – Patient Portal):
□ Unsure of date? Provide description of records needed _____
□ Most Recent (Approx. Date): ____/____/____ **OR** □ Specific Dates: ____/____/____ to ____/____/____

Records are needed by (Note – records from 2018 to present are available on My Health Info – Patient Portal):
□ As Soon As Possible (within 30 days) □ Specific Date: ____/____/____

How would you like your records delivered?
□ Secure Email: (Email listed above) □ Fax: (# listed above) □ Paper via US Mail
□ Paper Pick up in person (Entrance C) □ USB Drive Pick-up in person □ USB Drive via US Mail

Purpose of Request:
□ Continued Care □ Patient Request □ Insurance □ Legal □ Other _____

By signing this authorization form, I understand that:

- Requests for copies of medical records may be subject to copying fees.
- PHI may include records relating to behavioral/mental health care, STDs, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire six months from date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re disclosure, and the information may not be protected by federal confidentiality rules.

Signature: If signed by an authorized representative, supporting legal documentation must accompany this form.
Patient /Representative Signature: _____ **Date:** _____

Signature of Party Picking up Records: _____ **Relationship to Patient** _____

Internal Use Only v11.01	M#	ID Type/Checked By:	Fee:	Payment Type:	Logged by/ Date:	Billing Released By / Date:
	Record Type & F/A#:					

Staff Releasing Records: _____ Date: _____