

1. Patient Information:

Patient Name _____ Phone # _____
 Previous Name(s) _____ Date of Birth _____
 Address _____ Last four of SSN _____

2. I authorize Faith Health to release records to:

Facility / Person / Entity Name	Phone Number	Fax Number
Address	City	State / Zip Code

3. Release Format: Fax Mail CD Pick up Email _____

4. Dates to be released: _____

5. Records to be released:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultations	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Billing
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Clinics (Specify) _____	<input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Cardiology Reports	<i>I further authorize release of the following information:</i>	
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Mental Health Notes/Tests	<input type="checkbox"/> HIV/AIDS treatment/testing
<input type="checkbox"/> Radiology CD	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Chemical Dependency/Substance Abuse	

6. Purpose of this release:

Continuing Care Insurance Attorney Personal Use Other _____

This authorization expires on the following date, event, or condition: _____

If I do not specify any expiration date, event or condition, this authorization will expire 12 months from the date of my signature per NE Rev. Statute Section 71-8403 or upon satisfaction of the need for disclosure.

Statement of Authorization:

- I understand that, except for research and related treatment, Faith Health will not condition my treatment on my signing of this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Health Information Services (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once the information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
- I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.
- I understand that any non-Faith Health documents in my chart may not reflect any changes or updates made by the originating organization after releasing to Faith Health.

Signature of Patient/Legally Authorized Representative

Date

Relationship to Patient

Reason Patient is Unable to Sign

FAITH HEALTH

Records released by _____ MRN _____

Date mailed/faxed/picked up _____

Document Scan Type: Authorization to Release Protected Health Information
 Revised: 10/2025

