AUTHORIZATION FOR RELEASE OF INFORMATION

Faith Regional Health Services | Faith Regional Physician Services, LLC

Medical Records | M-F 8-4:30 | Phone: 402-644-7602, opt 5 | Fax: 402-644-7510
releaseofinformation@frhs.org | Patient Portal: www.onechartpatient.com

1. Patient Information:

Patient Name ______________________ Phone # ______________________

Previous Name(s) ______________________ Date of Birth ______________________

Address ______________________ Last four of SSN ____________

2. I authorize FRHS/FRPS 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:

❑ Discharge Summary	❑ Consultations	❑ Operative Report	❑ Billing
❑ History & Physical	❑ Progress Notes	❑ Clinics (Specify) ______________________	❑ Other (Specify) ______________________
❑ Emergency Room Report	❑ Cardiology Reports	***I further authorize release of the following information:***	
❑ Radiology Reports ❑ Radiology CD	❑ Lab Reports ❑ Pathology Report	❑ Mental Health Notes/Tests ❑ Chemical Dependency/Substance Abuse	❑ HIV/AIDS treatment/testing

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, FRHS 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-FRHS documents in my chart may not reflect any changes or updates made by the originating organization after releasing to FRHS.

______________________ ______________________
Signature of Patient/Legally Authorized Representative Date

______________________ ______________________
Relationship to Patient Reason Patient is Unable to Sign

FAITH REGIONAL HEALTH SERVICES

Records released by____________ MRN______________

Date mailed/faxed/picked up______________

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

PATIENT STICKER