UNMC Nebraska Medicine

ROI

PT NAME

MR #

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Street Address:	City:	State:	Zip:
Date of Birth (MM/DD/YYYY)	Telephone:	Email (optional):	

I hereby authorize and request release of my medical records:

FROM		**TO**	
Name		Name	
Address		Address	
City/State/Zip		City/State/Zip	

Information to be disclosed:

From Date		To Date	
☐ Discharge Summary	☐ EKG/EEG Reports	☐ Radiology Images	☐ Clinical Notes
☐ Radiology Reports	☐ Emergency Room Record	☐ Laboratory Results	☐ Operative Reports
☐ Physical/Occupational Therapy Notes	☐ Prenatal (Pregnancy) Report	☐ History and Physical Exam	☐ Pathology Report
☐ Substance Use Disorder Notes	☐ Drug Testing & Results	☐ HIV Testing & Results	☐ Genetic Testing & Results
☐ Psychiatric/Mental Health Information	☐ Other:		

From the following locations:				
☐ Entire health system	☐ The Nebraska Medical Center	☐ Bellevue Medical Center	☐ Village Point	☐ Primary Care Clinic

How would you like your records delivered?			
☐ Mail delivery	☐ In-Person Pickup	☐ OneChart Patient Portal	☐ Email:

Purpose of Release:			
☐ Continuation of Care	☐ Attorney	☐ Personal Records	☐ Other:

This statement of consent can be revokes at anytime before disclosure of the information and expires on _____/_____/20_____ (expiration of date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires twelve (12) months after this release is signed.

- I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.
- I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.
- PROHIBITION ON REDISCLOSURE OFALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: This information has been disclosed from records protected by federal law. 42 CFR. Part 2 prohibits any further disclosures of these records without specific written authorization of the person to whom it pertains, or as otherwise permitted by law.
- I understand Nebraska Medicine and its affiliates will not condition evaluation or treatment on whether I sign this authorization.
- FEES: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Please print your name and sign below:

Name of Patient or Personal Representative:	**Relationship (or Self):**
Signature of Patient or Personal Representative:	**Date:**

Please return completed form to:

Health Information Management– Release of Information
Nebraska Medicine
989100 Nebraska Medicine
Omaha, NE, 68198-9100
Fax: Attention HIM– ROI - Nebraska Medicine | Fax 402-559-6200

Questions?
Call 402-559-4024 from 8 a.m. to 5 p.m. Monday - Friday for help. At other times, please leave a voicemail

COPY IS AS VALID AS ORIGINAL

Nebraska Medicine
SERIOUS MEDICINE. EXTRAORDINARY CARE.

RELEASE OF INFORMATION

Mailing Address:
Health Information Management
Release of Information
989100 Nebraska Medical Center
Omaha, NE 68198-9100

Phone: 402-559-4024 **Fax:** 402-559-6200 or 402-559-3799

PROCESSING TIME

- Health Information Management requires a minimum of 72 hours or three business days after the written request is received to process
- Allow an additional 7-10 days for mailing time
- Requests for records created prior to 1999 make take additional time to research and process

COMPLETING THE AUTHORIZATION:

- Authorizations are valid for 12 months from the date of signing if no expiration date or identifiable event related to the individual is listed
- Requests made by anyone other than the patient must include:
  - Signature of the patient's representative and date
    - Relationship of representative to the patient
  - Persons other than the parent of a minor child must provide proof of legal authority to act on behalf of the patient. Legal proof includes guardianship, power of attorney, personal representative papers and other legal documents

- Charges do not apply when records are released to a doctor/medical facility for continuation of care.

CHARGES

Patient Pricing

How they are stored-------->	How they are released	Fee Information
Electronic - >	Electronic (Email, Portal, CD, Flash Drive)	$6.50 (electronic flat fee)
Electronic ->	Paper	$0.90 labor cost + $0.05 per page supplies + postage (if applicable)
Hybrid (Paper & Electronic) ->	Electronic (Email, Portal, CD, Flash Drive)	$6.50 (electronic flat fee) + $0.07 labor cost per paper page
Hybrid (Paper & Electronic) ->	Paper	$0.07 labor cost per paper page + $0.90 labor cost + $0.05 per page supplies + postage (if applicable)
Paper ->	Electronic (Email, Portal, CD, Flash Drive)	$0.07 labor cost per paper page
Paper ->	Paper	$0.07 labor cost per page + $0.05 per page supplies + postage (if applicable)