Cozad Community Health System

Cozad Community Hospital
PO Box 108 Cozad, NE 69130

Cozad Community Physical Therapy
PO Box 108 Cozad, NE 69130

Cozad Community Medical Clinic
1803 Papio Lane Cozad, NE 69130

Authorization for Release of Information

*****Please include a photo ID with request*****

I. Patient Name: _____ Date of Birth:_____
Address:_____ Phone Number:_____
(Street, City, State, Zip)

2. I hereby authorize and request release of my medical records:
From: _____
(Health care facility to send information)
_____
(Address: Street, City, State, Zip)
_____
(Phone Number)
_____
(Fax Number)

To: _____
(Name of entity or individual to receive information)
_____
(Phone Number)
_____
(Fax Number)
_____
(Address: Street, City, State, Zip)

3. Date(s) of Service to be disclosed: _____
(Month / Date / Year)
Delivery Method of Records: ☐ Mail ☐ Fax ☐ Pick-up ☐ Electronic Copy _____
Format: (e.g., PDF, CCDA, image, picture etc.) _____ (E-mail address)

4. Purpose of Disclosure: ☐ Treatment ☐ Insurance ☐ Legal Proceedings ☐ Other _____

5. Information Requested: ☐ Other _____

☐ Entire Medical Record	☐ Medication Record	☐ ER Record
☐ History & Physical	☐ Lab/Pathology Report	☐ Surgical Report
☐ Discharge Summary	☐ Radiology Report	☐ Financial Record
☐ Progress Notes	☐ EKG/ECG Result	Therapy: OPT ☐ OT ☐ST

6. I understand that my health information may contain information relating to: HIV/AIDS, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law. I authorize the release of information relating to:
☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS

7. l understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and maybe re-disclosed by the person receiving it. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time, in writing, prior to expiration. I understand my refusal to sign this form will not affect my ability to obtain treatment. I understand that I may view and copy the information described on this form as provided by federalprivacy regulations and that I will receive a copy of this form after I sign it.

_____ _____
Patient Signature or Patient's Representative Signature Date

_____ _____
Representatives Printed Name Relationship to Patient

_____ _____
Prepared By Date

Approved: 03/2022