University of Nebraska Medical Center

REGIONAL PATHOLOGY SERVICES

## *Guidelines for Completing the Authorization for Release of Medical Records*

**Who May Sign the Authorization Form**

- **The patient** (a spouse cannot sign unless they have legal authority).
- **A person with Power of Attorney (POA)** if the patient is unable to sign. A copy of the Power of Attorney document must be provided.
- **A parent or legal guardian** if the patient is under 19 years of age.
- **A legal guardian.** A copy of the guardianship documents must be provided.
- **The personal representative of a deceased patient's estate.** A copy of the death certificate and documentation showing appointment as the estate representative must be provided.

**How to Complete the Authorization Form**

**Step 1: Enter Patient Information**

**Step 2: Select the Records Requested**

Check the box or boxes that match the medical records or test results you are requesting.

**Step 3: Enter the Date(s) of Service**

Write the date(s) of service or the time period for the records you want.

**Examples:** Office visit on 01/25/2008; All records from 2007–2008

**Step 4: Choose How You Want to Receive Your Records**

● Mail ● Fax ● Pick up in person

If you mail or fax the completed authorization form:

- The signature must be notarized.
- Include a copy of a valid government-issued photo ID.

**Step 5: Submit the Completed Form by One of These Options**

● Mail ● Fax ● Pick up in person

**Step 6: Pick Up Records in Person**

Anyone picking up records must present a valid government-issued photo ID. If someone other than the patient will pick up the records, list that person's name on the authorization form.

**Monday through Friday - 8:00 a.m. to 5:00 p.m.**

| | |
|---|---|
| **University of Nebraska Medical Center**<br>42nd & Emile, 1st Floor Diagnostic Center<br>Omaha, NE 68198<br>Please let staff know you are picking up records for Regional Pathology Services | **Oakview Medical Building**<br>2727 S. 144th Street, Suite 160<br>1st Floor Laboratory<br>Omaha, NE 68144 |
| **Regional Pathology Services – Central**<br>300 N. 44th Street, Suite 110<br>Lincoln, NE 68503 | **Regional Pathology Services – North**<br>4911 N. 26th Street, Suite 108<br>Lincoln, NE 68521 |

**Questions?** If you need help completing the form, please call: **402-559-6420 | 1-800-334-0459**

**Please allow up to 30 days from the date we receive your completed form to process your request.**

**<u>Mailing Address</u>**
**Regional Pathology Services**
**981180 Nebraska Medical Center**
**Omaha, NE 68198**
**Fax: 402-559-9497**

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**FOR REGIONAL PATHOLOGY SERVICES USE ONLY**

**Date Received:** **Date Completed:**
**Records Released By** ☐ Mail ☐ Fax ☐ Picked Up in Person
**Government-Issued Photo ID Verified** ☐ Yes ☐ No
**Staff Member:**

***Place Patient Label Here***

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Notice to Recipient:** The medical records you receive contain confidential health information protected by federal and state law. These records may not be shared with another person or organization unless permitted by law or authorized in writing by the patient.

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**Patient Name:** _____

**Date of Birth (MM/DD/YYYY):** _____ **Phone Number:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **ZIP Code:** _____

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**Authorization to Release Records**
I authorize **Regional Pathology Services** to release my medical records to the person or organization listed below.

**Type of Records Requested** (check all that apply)
☐ Surgical Pathology Report ☐ Laboratory Test Results ☐ Other: _____

**Approximate Test Date(s) or Collection Date(s):** _____

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**Send Records To**
**Name of Person or Organization:** _____
**Street Address:** _____
**City:** _____ **State:** _____ **ZIP Code:** _____
**Fax Number (if applicable):** _____

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**Delivery Method**
Please choose one:
☐ Mail ☐ Fax ☐ Pick Up in Person

**Choose Pickup Location**
☐ University of Nebraska Medical Center (UNMC) ☐ Regional Pathology Services – Central (Lincoln)
☐ Oakview Medical Building ☐ Regional Pathology Services – North (Lincoln)

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**Patient Authorization**
I understand that I may revoke this authorization at any time by submitting my request in writing. Revocation will not apply to records already released before the written revocation was received.

**Patient Signature:** _____

**Date (MM/DD/YYYY):** _____

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**If Someone Other Than the Patient Is Signing** *Complete this section only if you are signing for the patient.*
**Representative Name:** _____
**Relationship to Patient:** _____
☐ Parent of Minor (Under Age 19) ☐ Legal Guardian ☐ Power of Attorney
☐ Personal Representative of Deceased Patient's Estate ☐ Other: _____
**Representative Signature:** _____
**Date (MM/DD/YYYY):** _____
**Documentation Provided** (check all that apply)
☐ Power of Attorney ☐ Guardianship Documentation ☐ Estate Representative Documentation
☐ Death Certificate (if applicable) ☐ Other: _____