Charles Drew Health Center

RELEASE OF INFORMATION FORM

Charles Drew Health Center Location- Required (check one)

___Main Clinic ___St. Richards ___Siena Francis ___Crown

___Belvedere ___Kellom ___King Science ___Northwest

___Campus for Hope ___Evans ___Florence ___Jackson

__OHS (Omaha Healthy Start) __FFL(Fathers for a Lifetime)

Method of Delivery:

- ☐ Pick Up
- ☐ Mail
- ☐ CD Copy
- ☐ Fax

Date Requested: ______________
Date Needed: _________________
Call when ready? Yes No

Please allow 7-10 business days to process request.

Required- Patient Name: __________________________________ Required (M-D-Y)- Date of Birth: ____________
Required-Address: ____ Required if applicable- Phone: _____________
Previous Name (if applicable):____________________________ Required if applicable SSN/ID#______________

Choose ONLY one:

☐ I hereby authorize my records from **Charles Drew Health Center** for disclosure to:

____

Phone: ________________________________ Fax: _______________________________

☐ I hereby authorize my records be sent from:

____

Phone: ________________________________ Fax: _______________________________

To: **Charles Drew Health Center at 2915 Grant Street, Omaha, NE 68111**

Phone: (402) 810-9799 or (402) 810-9798 Fax: (402) 453-1970 Medical Records

Required-Dates of Service: From: _______________________To: ____________________

Information to be disclosed:

- ☐ The entire health record including alcohol and substance testing or treatment, HIV/AIDS status or related information and Reproductive Health
- ☐ Complete medical records, including progress notes, visit notes, labs and x-ray reports
- ☐ Emergency/Urgent Care Reports
- ☐ Discharge Summary

*****Specific Authorization for Release of Information protected by State or Federal Law*****

- ☐ Mental health testing, counseling and treatment information
- ☐ Chemical dependency (drug and alcohol)
- ☐ Other:____

For purpose of (circle one): Continuity of Care Personal Reason Other: ______________

.**Required-Signature of Patient or Legal Guardian:**__________________________________ **Date:**_______

(Note: A parent or legal guardian must sign if patient is a minor in NE – under age 19 and in IA – under age 18)-except for Reproductive Health and HIV Testing. If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Relationship to Patient, if not the patient:

For Office Use Only

Information for Dr.__________ MR#_________ Faxed: Date_________ Mailed: Date___________ Initials____

Notice to Recipient: The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted (42CFR Part 2). A general authorization for release of protected health information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient