Lincoln Surgical Hospital takes care to protect the privacy and confidentiality of patients and their medical records. Patients who wish to request copies of medical records or have medical records sent to another party must provide written authorization to the Lincoln Surgical Hospital.

If you wish to request a copy of your medical records, please complete and sign the enclosed form. All sections must be complete in order for the authorization to be accepted. Please provide a current phone number.

You can submit your form in one of three ways:

1. **Fax the completed request to:**

   Medical Records at 402-484-9099
   Or
2. **Mail the request to:**

   Lincoln Surgical Hospital
   1710 South 70th Street, Suite 200
   Lincoln, NE 68506
   ATTN: Medical Records

   Or

3. **Hand** your completed form to the front desk staff of the Lincoln Surgical Hospital in an envelope labeled, Attn: Medical Records.

Requested medical records will be printed and released during regular business hours, Monday-Friday, 8am-5pm.

Mailed copies will be sent within 30 days of receipt of the completed authorization form.

Patient pickup can be completed 10 business days following the receipt of completed authorization form. Patient will be notified by e-mail or phone when medical record is ready to be picked up.

For questions, please call the Medical Records Department at 402-484-9028.

PATIENT INFORMATION RELEASE AUTHORIZATION

To avoid delay in receiving requested information, complete ALL sections. All sections must be completed in order for the authorization to be accepted.

Name of Facility: Lincoln Surgical Hospital (LSH)

Address of Facility: 1710 South 70th Street, Suite 200, Lincoln, NE 68506

Patient name: _____ DOB: _____

Address: _____ Phone #: _____

e-mail address: _____

WHO:

ACTION REQUESTED: (check one)

☐ Provide a copy of My **Health Record to** me.

☐ Release **My Health Record to**: _____

WHAT:

For this Authorization, **"My Health Record"** means (check one or more):

☐ Operative Report _____

Diagnostic Test/Results: ☐ Lab ☐ Radiology Report ☐ Pathology ☐ EKG done at LSH

☐ History & Physical done at LSH ☐ Progress Note

☐ Other: _____ ☐ Discharge Summary

☐ **Complete record -** ☐ Billing Record

Records are from: ☐ Lincoln Surgical Hospital (LSH) ☐ Lincoln Surgery Endoscopy Services (LSES)
This Authorization does NOT include records from other healthcare providers that are a part of my Lincoln Surgical Hospital records.
Dates (s) of service: _____ to _____*insert date(s) of service requested*

WHY:

The purpose and need for such disclosure:

☐ Per patient request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

Other: _____

FORMAT: (check one)

It is strongly recommended that your health record be provided via electronic means.

Electronic request fees: **No fee**

Paper record request fees: 10 pages and under: **No Fee.**

Over 10 pages: **$20 handling fee plus .50 per page (pre-payment required)**

No charge for paper or electronic health information if patient picks up record at hospital.

I request that the copy be provided (where possible/available):

☐ On paper (fees may apply) ☐ electronically on a password protected flash drive

☐ Electronically on a password protected CD ☐ Other electronic means (requires LSH approval)_____

☐ Patient pick-up **(no charge)** ☐ certified mail

Important: I understand that the electronic means, flash drive or C.D.is not encrypted and that it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device. Additionally, I understand that unencrypted e-mail is not secure – that means it could be intercepted and seen by others; in addition, I understand that there are other risks with unencrypted e-mail including misaddressed/misdirected messages; e-mail accounts that are shared; messages forwarded to others; and messages stored on portable devices having no security. By choosing to receive My Health Information on a flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.

I understand there may be a fee for a copy of My Health Information as defined above. I understand that all fees will be in compliance with applicable law. I agree to pay this fee. _____(Initial)

I understand that:

- The Hospital will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- This Authorization is voluntary. My treatment will not be impacted, no matter if I sign this Authorization or not.
- This Authorization is valid for 60 days from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here:_____
- I may revoke/withdraw this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the hospital where my Authorization was made or given.
- Once My Health Information is disclosed as requested, it may no longer be protected by federal and state privacy laws, and could be re-disclosed by the person(s) receiving it.
- The medical information released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

_____ _____

Signature of Patient *Date*

If you are NOT the patient but are signing on behalf of the patient, please complete below: You must attach proof of your authority to act on behalf of the patient as checked if other than parent.

☐ Parent with parental rights

☐ Court Appointed Guardian

☐ Medical Power of Attorney

☐ Other_____

_____ _____

Representative Signature *Date*

All sections of this form must be completed in order for the authorization to be accepted.

Copies will be sent within 30 days of receipt of the completed authorization form.

This form is valid for sixty (60) days from the date of signing.

For questions, please call the Medical Records Department at 402-484-9028.