Lincoln Surgical Hospital Nebraska Surgery Center
Proud to be Physician Owned

Medical Records Release with Cover Letter

HI3R

Lincoln Surgical Hospital and Nebraska Surgery Center take 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 or Nebraska Surgery Center.

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 these ways:

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

   Medical Records at 402-484-9046

   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 or Nebraska Surgery Center in an envelope labeled, Attn: Medical Records.

   Or

4. **Email** your completed form to lshmedrec@lincolnsurgery.com.

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

Copies will be sent within 20 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 email or phone when medical record is ready to be picked up.

For questions, please call the Medical Records Department at 402-484-0861.

Author/Reviewer:
Review Period: 2 years
Date effective:
Date reviewed:
Date revised: 9/2022

Lincoln Surgical Hospital Nebraska Surgery Center
Proud to be Physician Owned

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 Facilities: Lincoln Surgical Hospital (LSH) & Nebraska Surgery Center (NSC)

Address of Facilities Medical Records Department:

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 either ☐ **Complete record – (could be 100+ pages)**

Or select specific records to request (check one or more):

☐ Operative Report ____

Diagnostic Test/Results: ☐ Lab ☐ Radiology Report ☐ Pathology ☐ EKG

☐ History & Physical ☐ Progress Note

☐ Discharge Summary ☐ Billing Record

☐ Other: ____

Records are from (select one or all): ☐ All Facilities (LSH, NSC, LSES)

☐ Lincoln Surgical Hospital (LSH) ☐ Nebraska Surgery Center (NSC)

☐ Lincoln Surgery Endoscopy Services (LSES)

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: **No fee**

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

☐ On paper ☐ Electronically on a password protected flash drive ☐ Other electronic means (Fax, encrypted or unencrypted e-mail)

☐ Patient pick-up ☐ certified mail

Important: I understand that the electronic means, by flash drive 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 that:

- The Hospital/Surgery Center 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 20 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 402-484-0861.