University of Nebraska Medical Center

REGIONAL PATHOLOGY SERVICES

Guidelines for Completing the Release of Medical Record Authorization Form

The following people are authorized to sign for release of information:

- The patient (Not the spouse)
- Power of attorney, if patient is unable to sign (Document must be provided)
- Parent (If the patient is under the age of 19)
- Legal Guardian (Proof of guardianship document must be provided)
- Representative of the estate for deceased patients (Copy of death certificate and a copy of the representative of estate documents must be provided)

Completing the Authorization Form:

1. Print the following information: Patient name, date of birth, street address, city, state, zip code and phone number.
2. Check the appropriate box(es) that corresponds with the results that are being requested.
3. Write the date(s) of service or time frame for which you are requesting records (i.e. physician office visit 01/25/08 or all records from 2007-2008).
4. Write the name and address of the person to whom records will be released. If you want the results to be sent to yourself, please write your personal contact information in this section.
5. How would you like your results delivered?
    - Please indicate whether you would like your results mailed, faxed or picked up at one of our two facilities.
    - If someone other than the patient will pick up the records, write the responsible person(s) name on the bottom of the release of medical record form. You will be asked to present a photo ID when picking up medical records.
6. The form may be mailed, faxed or brought into one of our facilities. Please allow **12** business days for results to be available for pick up or mailed/faxed.
7. When picking results up in person, **you MUST bring a government issued photo ID.**
    - **The University of Nebraska Medical Center**, 42nd & Emile, 1st Floor Diagnostic Center; Omaha, NE 68198 (**let staff know you are there for Regional Pathology Services**).
    - **Oakview Medical Building**, 2727 So 144th Street, Suite 160, 1st Floor, Laboratory; Omaha, NE 68144
8. Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. The completed form may be mailed or faxed to the laboratory – **signatures must be notarized, and include a copy of a photo ID if the form is mailed or faxed**.

If you have questions about completing this form, please call 402-559-6420 or 1-800-334-0459.

****Note: Expect to receive results within 30 days of receipt of form.****

Mailing Address

Regional Pathology Services

981180 Nebraska Medical Center

Omaha, NE 68198

Fax: 402-559-9497

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RELEASE OF MEDICAL RECORD

Note to Recipient of Records: The patient's medical record is privileged information which is protected by various State and Federal Laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

1. I, _____ born _____

(Patient's Name) (Date of Birth)

_____

(Street Address) (City) (State) (Zip Code) (Phone Number)

Authorize Regional Pathology Services to release to the party listed in paragraph 2 the following information from my medical records:

Type of test: ☐ Surgical Pathology report ☐ Cyto-Pathology report ☐ Laboratory test results ☐ Other

Approximate test date or collection date: _____

2. My medical record may be inspected by and/or copies may be released to:

_____

(Name of Person) (Fax number)

_____

(Street Address) (City) (State) (Zip Code) (Phone Number)

How would you like your results delivered: ☐ Mail ☐ Fax

☐ Will Pick Up (Complete information below) **Please allow 12 business days**

Location: ☐ UNMC ☐ Oakview Medical Building Date: _____ Time: _____

3. I may revoke this authorization in writing at any time (except to the extent those actions have been taken in reliance upon it).

_____ _____

(Patient's Signature) (Date)

If the patient is a **minor (under the age of 19)**, subject to a guardianship or is deceased, I have signed my name below on behalf of the patient and myself:

_____ _____

(Patient's Legal Guardian's or Agent's Signature) (Date)

RPS USE ONLY Received ___/___/____ Completed ___/___/____ Sent: Fax ____ Mail ____ In Person ____ Government issued picture ID verified _____ RPS staff name verifying ID _____	PLACE PATIENT RPS PATHWAY LABEL HERE