



AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Fax: 531-355-0006

Email: medical.records@boystownhospital.org

MR# _____

Patient Name: _____	Date of Birth: _____
Address (including City/State/Zip): _____	
Phone Number: _____ Email _____ @ _____	

Release Information From:

Provider/Facility Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax _____

Release Information To:

Address: _____

City/State/Zip: _____

Phone: _____ Fax _____

Information to be Released: _____ **Service Dates:** From: _____ To: _____

Clinic		Hospital		Ancillary		Other
<input type="checkbox"/> Allergy	<input type="checkbox"/> Neurology	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> CT/MRI	<input type="checkbox"/> Immunization Record		
<input type="checkbox"/> Audiology/Cochlear	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Behavioral Health/IRTC	<input type="checkbox"/> EEG	<input type="checkbox"/> Itemized Billing Records		
<input type="checkbox"/> Craniofacial	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> EKG	<input type="checkbox"/> Nutrition		
<input type="checkbox"/> Ear, Nose, Throat	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Lab	<input type="checkbox"/> School/Work Release		
<input type="checkbox"/> GI	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Sleep Study	<input type="checkbox"/> Verbal Communication		
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Speech & Language	<input type="checkbox"/> Operative Report	<input type="checkbox"/> X-ray			
Other: _____						

Purpose for which information is to be used:

- | | | |
|---|---|---|
| <input type="checkbox"/> Treatment/Referral | <input type="checkbox"/> Insurance | <input type="checkbox"/> Evaluation |
| <input type="checkbox"/> Changing Doctors | <input type="checkbox"/> Personal/At Request of Patient | <input type="checkbox"/> Other (Please specify) |

State and federal law protect the following information. Please check the box if you want to include this information with your records.

- Alcohol, Drug, or Substance Abuse Records HIV Testing & Results

Release Format: Paper CD/DVD **Release Method:** Mail Pick up Fax Email Portal

By signing this authorization form, I understand that:

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at Boys Town National Research Hospital at 555 North 30th St. Omaha, NE 68131. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire in one year from the date signed or on the following date/event/condition _____, whichever occurs sooner.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I acknowledge that I have read and fully understand the E-mail Consent Form on the back of this form and that all record disclosures via email shall be encrypted.

Patient or person authorized to sign for patient

Relationship to Patient

Witness

Date

**BOYS TOWN NATIONAL RESEARCH HOSPITAL
E-MAIL CONSENT FORM_**

1. Risk of Using E-mail

Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail. These include, but are not limited to, the following risks:

- E-mail can be circulated, forwarded and stored in numerous pages and electronic files.
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail senders can easily misaddress an e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient(s) has deleted his or her copy.
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail can be used to introduce viruses into computer systems.
- E-mail can be used as evidence in court.

2. Conditions for the Use of E-mail

BTNRH will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, BTNRH cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by BTNRH's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes the patient's express agreement with the following conditions:

- a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical records. Other individuals authorized to access the medical records, such as staff and billing personnel, will have access to those e-mails.
- b. Provider may forward e-mails internally to Provider's staff and agents as necessary for diagnosis treatment, reimbursement, and other health care operations, or externally to entities performing contracted services on behalf of BTNRH. Those entities are regulated in the same manner as BTNRH.
- c. Although BTNRH will endeavor to read and respond promptly to an e-mail from the patient, BTNRH cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, patients should not use e-mail for medical emergencies or other time-sensitive matters.
- d. If the patient's e-mail requires or invites a response from the Provider, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability or substance abuse.
- f. The patient is responsible for informing BTNRH of any types of information the patient does not want to be sent by e-mail, in addition to those set out in 2(e) above.
- g. The patient is responsible for protecting his/her password or other means of access to e-mail. BTNRH is not liable for breaches of confidentiality caused by the patient or any third party.
- h. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. Instructions

To communicate by e-mail, the patient shall:

- a. Limit or avoid use of his/her employer's computer.
- b. Inform BTNRH of changes to his/her e-mail address.
- c. Put the patient's name in the body of the e-mail.
- d. Include the category of the communication in the e-mail's subject line, for routing purposes (for example, billing question).
- e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to a BTNRH Provider.
- f. Inform BTNRH that the patient received an e-mail from a BTNRH Provider.
- g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.
- h. Withdraw consent only by e-mail or written communication to BTNRH.

4. Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this E-mail Consent Form. I understand the risks associated with the communication of e-mail between my BTNRH Provider and me, and consent to the conditions outlined above. In addition, I agree to these instructions, as well as any other instructions that BTNRH may impose to communicate with patients by e-mail. Any questions I had, were answered. I understand that I may withdraw my consent only by e-mail or written communication to BTNRH, which shall only be effective after receipt by BTNRH.