**York General**
**2222 N. Lincoln Ave. York NE 68467**
# Authorization for Release of Health Information

ROI

Today's Date: _____ Purpose of Disclosure: Continued Medical Care of Patient

York General is Requesting Medical Records **from**: _____

Facility Phone: _____ Facility Fax: _____

Patient Name: _____ Birthdate: ____/_____/_____

Date of Visit(s) _____

Information to be released:

__ Discharge Summary
__ Operative Report
__ History and Physical
__ Consultation
__ View ONLY
__ Specialty Clinic Report
__ Emergency Room Report
__ Pathology Report __ LAB Report
__ X-Ray Results
__ HIV/AIDS information
__ Face Sheet
__ Nursing Notes
__ EKG Results
__ Medication Record
__ Other _____

Expiration date/event for this authorization: _____

*This authorization shall be valid for one year (365 days) from the date listed unless otherwise specified.*

York General Rep Signature _____ Date _____ Time _____

## Send Medical Records to York General Hospital

Attention/YGH department: _____

Fax number: _____

Number of pages: _____

If you have any questions please contact York General HIM department at 402-362-0452.