Dundy County Hospital
PO Box 626
Benkelman, NE 69021
308-423-2204 (Switchboard)
308-423-2968 (Fax)

Quality Healthcare Clinic
PO Box 710
Benkelman, NE 69021
308-423-2151
308-423-2217 (Fax)

WEBSITE:
dchbenkelman.com

Family Practice
Jose R. Garcia, Sr., MD
Lori L Stonehocker, DO
Tammi Cawthra, APRN-C
Michelle Koppie, APRN-C
Brandy Hanes, APRN-C

Cardiology
Sean Denney, MD
Barry Molk, MD
Georgy Kaspar, MD

General Surgery
James C. Schiefen, DO

Oncology/Hematology
Benjamin George

Neurology
H. Rai Kakkar, MD

Orthopedics
Mandip Singh

Podiatry
Robert Hinze, MD

Pain Management
J. Paul Meyer, MD

Psych/Counselling
Renee Ruhlman, LIMHP, LMHP, LPC

Trisha Jobman, APRN-NP

Authorization for Release of Health Information

Patient's Name: ____________________________________ **DOB:** _______________

Address: _______________________________ **Phone #:** _____________________

City/State/Zip Code: ____

PLEASE COMPLETE ONE BOX ONLY

{ } I authorize Dundy County Hospital to **RELEASE** information to:	{ } I authorize Dundy County Hospital to **OBTAIN** information from:
________________________________ Name	________________________________ Provider and/or Facility Name
________________________________ Address	________________________________ Address
________________________________ City/State/Zip Code	________________________________ City/State/Zip Code
________________________________ Phone #	________________________________ Phone #
________________________________ Fax #	________________________________ Fax #

Date of Service or Time Period to be Disclosed:

____

Information:
- { } Radiology Reports/CD's
- { } Laboratory Reports
- { } Specialty Clinic Notes
- { } 5 years Medical Records
- { } Other: ______________________

Purpose:
- { } Legal / Insurance
- { } Patient Request
- { } Transfer of Records
- { } Other:______________________

Authorization for Release of Information Protected by State or Federal Law

I hereby specifically authorize the release of data and information relating to:
{ } HIV/AIDS related testing { } Drug/Alcohol Dependence { } Mental Health

This authorization will be valid for 180 days from the date that it is signed. This authorization may be revoked at any time by notifying the above-named provider of information in writing, unless this authorization was received as a condition for obtaining insurance coverage. Any release of information made in compliance with this authorization before my revocation shall not constitute a breach of my rights to confidentiality. Dundy County Hospital and its affiliates do not condition treatment or payment based on this signature on authorization for disclosure. Information used/disclosed through this authorization is no longer protected or guaranteed by Dundy County Hospital.

There will be a flat fee charged of $20.00 for records consisting of over 100 pages.

____
Print Patient Name

____ ___________________
Signature of Patient or Legal Guardian/Relationship Date

ROI Completed by: ___________________________________ Date: ______________