Authorization to Release Patient Information

Citizens Memorial Healthcare (CMH)
1500 North Oakland
Bolivar, Missouri 65613
Ph: 417.328.6304 Health Information Management
Fax: 417.328.1110

REQUESTED FROM:

☐ Hospital (CMH)

☐ Clinic _____

☐ Physician_____

☐ OTHER:_____

_____

REQUESTED DATES or TYPES OF SERVICE/TREATMENT:_____

_____

_____

PATIENT IDENTIFICATION:

Patient Name:

_____

Birth Date:

_____

Social Sec #:

_____

Address:

_____

City/State/Zip:

_____

Phone:

_____

SEND TO:

☐ Self *(Patient)*

☐ Other (*Please Specify Below)*

Name:

_____

Address:

_____

City/State/Zip:

_____

Phone:

_____

CHECK BELOW INFORMATION REQUESTED

☐ Complete Health Record

OR

☐ History & Physical	☐ Lab Results
☐ Discharge Summary	☐ Radiology Reports
☐ Operative Reports	☐ Radiology Film/CD
☐ Consultations	☐ Pathology
☐ ED Records	☐ Therapy Notes
☐ Immunizations	☐ Newborn Record
☐ Itemized Bill	☐ Newborn Screen
☐Mammo Film/CD	☐Mammo Reports
☐ Permanent Transfer	☐ Temporary Transfer

OTHER:_____

PATIENT REQUESTS ONLY

☐ **I understand my records will be sent by Encrypted Email**

_____

☐ **Other Format Requested**

_____

(we **FAX ONLY** to other healthcare organizations)

☐ Fax

_____

Deliver By:

☐ Mail

☐ Pick Up

PURPOSE FOR REQUEST

☐ Treatment

☐ Patient Request

☐ Billing/Claims

☐ OTHER (specify):

_____

_____

_____

_____

_____

1. This authorization is voluntary. I can inspect or copy the protected health information to be used or disclosed.
2. This authorization will expire_____ (e.g. 60 days) or one year from the date of the signature below.
3. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the facility for the release of requested information.
5. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
6. I understand that if the persons or entities to which I am asking that the Provider disclose this information are not covered by federal privacy regulations, then this information will no longer be protected under federal privacy law and could be subject to re-disclosure.
7. I understand that if I wish to have copies of records made, then the facility may assess a fee for copying the records or x-rays. I will be notified of the total amount due for copying and shipping the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs. I can inspect or copy the protected health information to be used or disclosed.
8. I understand that Citizens Memorial Healthcare cannot condition admission to the facility upon my providing this authorization.

I understand that my medical or billing record may contain information in reference to drug and/or alcohol treatment, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing, status and/or treatment, and/or other sensitive information, and I agree to its release. I understand that if I authorize the release of Drug and Alcohol Abuse treatment records that those records are protected by Federal Law.

_____ _____

Signature of Person Making Request Date Print Name of Person Making Request

Relationship if not patient: _____ Identification Verified: ☐ Yes ☐ No