

Authorization to Release Patient Information

Citizens Memorial Hospital (CMH)/Citizens Memorial Health Care Foundation Health Information Management
1500 North Oakland, Bolivar, MO 65613 | Phone: 417.328.6304 | Fax: 417.328.1110

Records requested from:

- Hospital (CMH) _____
- Clinic _____
- Long Term Care _____
- Other _____

Requested Dates or Types of Services/Treatments

Patient Information

Name _____
Date of Birth _____
Social Security # _____
Address _____
City, State, Zip _____
Phone _____

Send to: Self Other Other Healthcare

Name _____
Address _____
City, State, Zip _____
Phone _____
Email _____
Fax _____

Deliver By: Email/Electronic (patients only) Mail
 Fax (other healthcare facilities only) Pick Up

Check Below for Information Requested

* Complete (All records, consents, notes, meds, vital signs, etc.)

- Consultations Immunizations Operative Reports
- Complete Lab Results Pathology
- Discharge Summary Mammo Reports Radiology Film/CD
- ED Records Mammo Film/CD Radiology Reports
- History & Physical Newborn Records Therapy Notes
- Other _____

Purpose for Request

- Treatment Transfer
- Patient Request Legal
- Billing/Claims Other _____

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 once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that any recipient to 42 CFR part 2 protected information must comply with part 2 protections and may not re-disclose the information except as permitted by part 2. 42 CFR §2.32.

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 _____ Date _____

Printed Name of Person Making Request _____

Relationship if not patient _____

Identification Verified Yes No

Definition of a "COMPLETE" Hospital Record

History and Physical	Therapy Notes
Discharge Summary	Pathology
Operative Reports	Newborn Records
Consultations	Medication Summary (MARS) *
Emergency Room Records	Nursing Notes *
Immunizations	Surgical Record
Lab Results	Physician Orders
Radiology Reports	Signed Consents
Radiology Film/CD	EKG/Rhythm
Mammogram Reports	OBIX/Fetal Monitor Strips
Mammogram Film/CD	

*These items can be extensive and can result in hundreds of pages.

How do I get a copy of my medical records?

Fill out an Authorization Form

Fill out the form completely (leave no blanks) to avoid any delays.

Time frame to obtain your records

We request a reasonable amount of time to fill your request. Please allow 3 - 5 business days.

Effective January 13, 2020

Fees are dependent on how records are stored and how they are delivered. See table below for more information.

Patients			
Requestor Type	Type	Legal Authority	Reproduction Fee Paper/Electronic
Patient/Delivered Electronically	Stored and Delivered Electronically	OCR	\$6.50 Flat Fee Elect
	Paper Delivered Electronically	OCR	\$.07pp Fee Paper
	Paper & Electronic Delivered Electronically	OCR	\$6.50 Fee Elect
Patient/-Delivered Paper	Paper Delivered Paper	OCR	\$.07pp Fee Paper
	Stored Electronic and Delivered Paper	OCR	\$.90 Flat Fee Elect
	Paper & Electronic Delivered Paper	OCR	\$.90 Flat Fee Elect, plus \$.07pp Fee Paper
Patient/Electronic Device (CD/Flash Drive)	Electronic to CD (Mailed)	OCR	\$6.50 Fee Elect
	Electronic and Paper to CD (Mailed)	OCR	\$6.50 Fee Elect
	Paper to CD (Mailed)	OCR	\$.07pp Fee Paper
	Electronic to CD (On-site pick up)	OCR	\$6.50 Flat Fee Elect
	Electronic and Paper to CD (On-site pick up)	OCR	\$6.50 Fee Elect
	Paper to CD (On-site pick up)	OCR	\$.07pp Fee Paper