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

*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.