Authorization for the Release of Health Information

I, the undersigned authorize and request Ozarks Community Health Center to:

Release From:	***Send To:***
Name:_____	Name: _____
Address:_____	Address: _____
City/Zip:_____	City/Zip: _____
Phone #: _____	Phone #: _____
Fax #:_____	Fax #:_____

PATIENT IDENTIFICATION

Name_____	Social Security Number_____
Address_____	Date of Birth_____
City/Zip_____	Phone Number:_____

Deliver Records By:
☐ Mail ☐ Pick Up ☐ Fax

Date(s) Requested: ____/____/____ to ____/____/____
Date(s) Requested: ____/____/____ to ____/____/____

Check below the items to copied/released:

___ Complete Health Record (s)	___ Therapy Notes	___ Progress Notes	___ Lab Results
___ History & Physical	___ Consultations	___ ED Records	____ Newborn Screening
___ Discharge Summary	___ Radiology Reports	___ Immunization Records	____ Newborn Records
___ Pathology	___ Radiology Film/CD	___ Operative Reports	____ Photographs, Videotapes
____ Other (Specify)_____		___ Itemized Bill	____ Permanent Transfer
_____		___ Mammo Films & Reports	____ Temporary Transfer

Purpose for which records will be used: ☐ Treatment or consultation ☐ At the request of the patient ☐ Billing or claims payment
☐ 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 Ozarks Community Health Center 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 Printed Name of person making request Date

Relationship if not patient: _____

Identification verified by: □ Photo ID □ POA
□ Matching Signature □ Court Order
□ Other: _____