OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient (printed)	Previous Names (If applicable)
Date of Birth	Telephone Number (s)
Address	Social Security Number
City State Zip code	Email (if applicable)

Purpose of Disclosure: Check appropriate box or write in other purpose:

◯ Self ◯ Legal ◯ Workers' compensation
◯ Continuity of Care ◯ Forms completion ◯ Other, please specify
◯ Disability ◯ Insurance ____

Information to be Released From:

◯ Medical ◯ Dental ◯ Behavioral Health

Send information to: (MUST be specific)

____
Recipient/Hospital/Provider Name

____ ________________________________
Address *Phone Number*

____ ________________________________
City *State* *Zip code* *Fax Number*

Expiration:

This authorization will expire in 1 year from date of signature unless another date is specified ___________________________

◯ I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked

◯ I authorize the release of records for future visits after the date of my signature until this authorization expires or is revoked

Delivery of Information:

◯ Pickup at OCHC – Hermitage Medical Center ◯ Fax (number listed above)
◯ Mail (address listed above) ◯ Email Address: ___________________________

◯ *Unencrypted email: The risks of receiving medical records via unencrypted email have been explained to me, including the risks of being hacked or interception by an unintended recipient. Despite being advised of these risks and encouraged to receive records through an encrypted email, I wish to receive the records requested via unencrypted email.*

Information to be Disclosed:

Dates of Service: ____

◯ Complete Health Record ◯ Therapy Notes ◯ Progress Notes ◯ Lab Results
◯ History & Physical ◯ Consultations ◯ Discharge Summary ◯ Radiology Reports
◯ Immunization Records ◯ Pathology ◯ Newborn Records ◯ Radiology Film/CD
◯ Photographs ◯ Itemized Bill ◯ Other, Specify: ___________________________________

Permanent Transfer of records ◯

Terms of Release:

- This authorization is voluntary. I can inspect or copy the protected health information to be used or disclosed.
- 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 notification.
- I agree to waive all claims against the facility for the release of requested information
- 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.
- I understand that if the persons or entities to which I am asking 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.
- 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 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.
- I understand that Ozarks Community Health Center cannot condition care based upon my providing this authorization.

I understand 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, those records are protected by Federal Law.

Note: A patient, 18 years or older, must authorize the release of their own information unless the patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situations may require minor's authorization.

____ ____________________

Signature (Required) Date (required)

____

Printed Name of Person Signing (if not patient) (First, Middle Last)

Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required)

◯ Parent ◯ Stepparent ◯ Legal Guardian ◯ Foster Parent ◯ Healthcare Power of Attorney/Agent

◯ Other: ___________________________________

Facility Use: Date Received: ______________ Medical Record Number: ___________ Date Info Released: ___________

Verbal consent was obtained for this release of information. The following 3 questions were asked and answers verified:

◯ Last 4 of SSN ◯ Emergency Contacts ◯ Insurance Carrier ◯ Reason for last visit ◯ PCP

Verbal consent obtained by: ___________________________________ Date/Time of Call: ______________