OZARKS COMMUNITY HEALTH CENTER
MEDICAL • DENTAL • BEHAVIORAL HEALTH

MEDICAL RECORDS RELEASE

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

RECORDS REQUEST DETAILS

Entity RELEASING Records

Entity Name: _____ Contact Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Entity RECEIVING Records

Entity Name: _____ Contact Name: _____

Address: _____ City:_____ State:_____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Information Release Details

Reason for Disclosure: _____

Information to be Disclosed: _____

Expiration:

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

◯ I allow the ongoing exchange of information to OCHC 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:

◯ Encrypted Email to: _____ ◯ Fax (*number listed above*)

◯ Mail (*address listed above*)

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 information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law. 42 CFR Part 2 prohibits the unauthorized re-disclosure of alcohol/substance use disorder treatment records.
- 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 hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record or a summary of the narrative of my protected health information to the physician/person/facility/entity shown above.

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: _____