OZARK CENTER
An affiliate of Freeman Health System
CONSENT AND AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

For disclosure for Ozark Center/Freeman Health System purposes or from another healthcare provider, Ozark Center will not condition treatment, payment, enrollment in a health plan or eligibility for benefits upon your signing of this authorization and you may refuse to sign this authorization form based upon these types of disclosures.

Requests for medical records and/or non-document materials may be subject to fees.

I, ______________________________ born, ______________
(name of client) (date of birth)

consent to and authorize ______________________________

to furnish ______________________________
(person or facility, address, city, state, zip and phone number)

The following records:

- ☐ Medication Notes
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Medical Source Statement
- ☐ Individual Substance Abuse Profile
- ☐ Assessment
- ☐ Discharge/Exit Summary
- ☐ Other: ______________
- ☐ Progress Notes
- ☐ History and
- ☐ Physical Labs
- ☐ Treatment Plan

The client records listed EXCEPT the following:

- ☐ relating to care and treatment for mental health conditions
- ☐ relating to care and treatment for drug or alcohol abuse
- ☐ relating to genetic testing and genetic testing results
- ☐ relating to HIV testing, infection status, or care and treatment for AIDS

Method of Delivery:

- ☐ US Mail-Paper
- ☐ email ______________
- ☐ CD-Secure Electronic format
- ☐ Pick up ROI department
- ☐ Fax ______________
(Fax # Immediate purposes only)

Specific Dates: from ______________ to ______________

Purpose of disclosure: ☐ Coordination of Care ☐ Litigation ☐ Legal ☐ Applying for Social Services

☐ other ______________________________

The consent and authorization expires on or event ______________ or within 90 days of the date signed if I have not provided an expiration date. A photo or fax copy of this consent and authorization shall be considered as effective and valid as the original

I understand that I may revoke this authorization at any time by signing a Revocation Form and returning it. A revocation form can be obtained from the Medical Record Releases Department. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on the authorization. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and therefore, no longer protected by the rule.

______________________________ ______________________________
Client signature Date ☐ Parent of Minor ☐ Guardian Date

______________________________ ______________________________
Printed Name of authorizing party ☐ Other personal representative (explain)

______________________________ ______________________________
Witness Signature Date Sign here if two signatures are required by law

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2), or by Section 191.656.R.S.Mo. (1991). The Federal rules and Missouri law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or Section 191.656. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

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Client Name: DOB: OC#: