OZARK CENTER
An affiliate of Freeman Health System
CONSENT AND AUTHORIZATION FOR RELEASE OF PATIENT 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.

I, _____, born_____,
(name) (date of birth)

consent to and authorize _____

to furnish to

_____
(person or facility, address, city, state, zip)

the following records:

☐ Medication Notes	☐ Individual Substance Abuse Profile	☐ Progress Notes
☐ Psychiatric Evaluation	☐ Assessment	☐ History and Physical
☐ Psychological Evaluation	☐ Discharge/Exit Summary	☐ Labs
☐ Other:_____	☐ Other:_____	☐ Other:_____

☐ The patient 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 HIV testing, infection status, or care and treatment for AIDS

Will you allow us to fax your information? ☐ Yes ☐ No

Dates of service requested:_____

For the purpose of _____
(reason for disclosure)

The consent and authorization expires on _____ 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.

_____
If not signed by subject of disclosure, specify basis of authority to sign: ☐Parent of Minor ☐ Guardian Date
☐ Other personal representative (explain)

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

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 patient.