



**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

Freeman Health System 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. All sections must be completed in order to be valid in accordance with 42 CFR Parts 160 and 164.

Copies of medical records and/or non-document materials may be subject to fees.

Patient Name: _____ Maiden or Other Names: _____

Date of Birth: _____ Phone: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

- Patient is Deceased Patient is a Minor and/or I am their Parent/Legal Guardian

I request my protected health information be released FROM:

- Freeman Hospitals (Joplin, Neosho, Fort Scott): _____ (Location) Ozark Center (all locations)
- Freeman Urgent Care (Joplin or Webb City) _____ (Location) Occumed
- Freeman Clinic/Physician Office/Other: _____ (Name & Location)

OR:

- I am requesting records from another facility/provider be sent to Freeman Health System:

Name of Facility/Provider: _____

Facility Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax#: _____ Email: _____

I request my protected health information (PHI) be released TO:

Recipient Name: _____

Recipient Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax# _____ Email _____

I request release of the following records and/or protected information:

- Abstract/Pertinent Summary (All Physician Dictation and test results)
- Emergency Room Record
- Pathology Reports / Pathology Slides
- Laboratory Results
- Radiology Reports
- Radiology CD Radiology iCloud
- Mental Health Care Treatment Records
- Substance Use Treatment Program Records
- Medical Source Statement
- Complete Billing Itemized Billing
- Complete Medical Record (All Medical Records)
- Other: _____

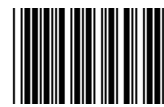
Records from time period: (Specific dates or years) from _____ to _____

How information is to be received by recipient:

- US Mail-Paper Email: Fax CD-Secure Electronic Format Pick up in person

Purpose of disclosure: Coordination of Care Legal Personal Other _____

Send to roi@freemanhealth.com Fax: 417-347-6842
Mail to: Freeman Health System,
Atten Medical Records 1102 W. 32nd St. Joplin, MO 64804



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