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

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.

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

I, Enter name., OC Number. born, Date of birth. consent to and authorize Person/Place providing info. to furnish to Person/place receiving info, address, city, state, zip and phone number..

The following records and/or protected information:

- ☐ Medication Notes
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Medical Source Statement
- ☐ Individual Substance Use Profile
- ☐ Assessment
- ☐ Other: Enter text.
- ☐ Discharge/Transfer Summary
- ☐ 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 and alcohol use
- ☐ 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: Enter email.
- ☐ CD-Secure Electronic Format
- ☐ Pick up ROI Department
- ☐ Fax # Enter fax number.

Records from time period: (Specific Dates) from Enter a start date. to Enter an end date.

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

This consent and authorization expires on the following date or event Enter a date. 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 Records 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	Enter a date. Date	_____ ☐ Parent of Minor ☐ Guardian Signature	Enter a date. Date
Enter Printed Name Printed Name of authorizing person	Enter a date. Date	_____ ☐ Other personal representative (Explain relationship) _____	Enter a date. Date
_____ Witness Signature	Enter a date. Date	_____ If 2 signatures required, sign	Enter a date. Date

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR part 2), Section 191.656.R.S.Mo (1991), or the HIPAA Privacy Rule (45 CFR parts 160 and 164). 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, Section 191.656, or 45 CFR parts 160 and 164. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of lawful substance use treatment information, mental health information, and reproductive health information to criminally investigate or prosecute an individual.