

All sections of this author	ization form <u>MUST</u> be completed to be valid ir	roi@freemanhealth.com accordance with 42 CFR Parts 160 and 164
Patient Name:		Date of Birth:
		State: Zip Code
	_ Maiden or other names:	
I request my protected health informat	ion (PHI) be released from:	
 Clinics ↓ [] Cornell-Beshore Cancer Institute [] Freeman Heart Institute [] Freeman Midwest Orthopedics [] Freeman Nephrology and Dialysis [] Freeman Wound Care 	Hospitals ↓ [] Freeman Hospital East and West [] Freeman Neosho Hospital [] Occumed	 ER and Urgent Care ↓ [] Emergency Room (Joplin and/or Neosho) [] Urgent Care - Joplin [] Urgent Care - Webb City
[] Other (Specific Provider Location / Pr	ovider Name/ or Doc Type):	
I request my protected health informat	ion (PHI) be released to:	
Name:	Email:	
		(immediate purposes only):
* I authorize the following PHI to be rele		(initice purposes only)
 [] Abstract/Pertinent Summary* * dictated reports and test results [] Complete Medical Record (all pages) [] Other: 		[] Itemized Billing [] UB-04 Claim Form [] 1500 Claim Form
Covering the period of health care from	:	
	to	
Purpose for requesting information:	How Information is to be received (if n	ot marked namer is default)
	·	··· · ·
[]Legal []Insurance []Personal []Continuation of Car	[] US Mail - paper format re [] CD - Secure electronic format	[] Fax (immediate purposes only) [] Pick up copies in the Department [] Email
By signing this authorization form, I und	lerstand that:	
 I have the right to <u>revoke</u> this authorization at 1102 W. 32nd Street, Joplin, MO 64804. Unless otherwise revoked, this authorization If I fail to specify an expiration date/event/c <u>Treatment, payment</u>, enrollment or eligibility Any disclosure of information carries with it I authorize the release of any information 	tion contained in the above records concerning sychiatric/psychological condition, psychiatric	presented to the Medical Records Department ady been released in response to this authorization. <u>of the date signed</u> . bt I sign this authorization. formation may not be protected by federal confidentiality rules. g treatment of drug or alcohol abuse ,
		anization described above. Patient Initial Here:
Patient/ Authorized Representative Signation	ature:	Date:
Printed Name of authorized Representat	ive:	Relationship to Patient:
Witness Signature:		Date:
If signed by a patient's author	ized representative, supporting legal documen	tation must accompany this authorization form