Authorization for Release of Information

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All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

Patient Name: ______________________________ Date of Birth: ______________

Address: ____________________ City: ______________ State: ________ Zip Code ________

Phone: ______________ Maiden or other names: ______________________

I request my protected health information (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 / Provider Name/ or Doc Type): ______________________

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

Name: ______________________ Email: ______________________

Address: ______________________________ Phone: ______________________

City/State: ________________ Zip Code: ________ Fax (immediate purposes only): ____________

*** I authorize the following PHI to be released from my medical record(s):**

[ ] Abstract/Pertinent Summary*
 * dictated reports and test results
[ ] Complete Medical Record (all pages)
[ ] Emergency Room Record
[ ] Laboratory Reports
[ ] Radiology Reports
[ ] Itemized Billing
[ ] UB-04 Claim Form
[ ] 1500 Claim Form

[ ] **Other:**____

Covering the period of health care from:

[ ] Specific Date(s):______________________ to ______________________

Purpose for requesting information:

[ ] Legal [ ] Insurance
[ ] Personal [ ] Continuation of Care

How Information is to be received (if not marked, paper is default)

[ ] US Mail - paper format
[ ] CD - Secure electronic format
[ ] Fax (immediate purposes only)
[ ] Pick up copies in the Department
[ ] Email

By signing this authorization form, I understand that:

* Requests for copies of medical records and/or non-document material may be subject to copying fees.
* I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Medical Records Department at 1102 W. 32nd Street, Joplin, MO 64804. Revocation will not apply to information that has already been released in response to this authorization.
* Unless otherwise revoked, this authorization will expire on the following date/event/condition: ______________________.
 If I fail to specify an expiration date/event/condition, this authorization will expire within 90 days of the date signed.
* Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
* Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

*** I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and or HIV related conditions. Patient Initial Here: ______________**

*** I authorize the release of any info. pertaining to genetic testing to the person or organization described above. Patient Initial Here: ________**

Patient/ Authorized Representative Signature: ______________________ Date: ______________

Printed Name of authorized Representative: ______________________ Relationship to Patient: ____________

Witness Signature: ______________________________ Date: ______________________

If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form

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