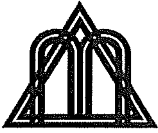

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

You have a right to review our Notice of Privacy Practices before signing this Authorization.

Information checked below is requested for: Patient: ______________________ **DOB:** ____________

SSN: ____________ **for records created between the dates** ______________ **&** ______________

___ Entire Record (except research records and psychotherapy notes) ___ Summary of health information ___ Surgical Reports
___ X–rays ___ Test Reports ___ Photographs/films Other: ______________________

This authorization: (check each category that applies)

Includes___ **Excludes** ___ HIV/AIDS Test Results and Treatment Records
Includes___ **Excludes** ___ Mental Health Care Records (except psychotherapy notes)
Includes___ **Excludes** ___ Drug/Alcohol Treatment Records

Purpose of use & disclosure: ___self ___transfer of care ___present care ___ specialist other: ______________

Person or organization information to be released from	**Person or organization receiving information**
Name ______________________	Name ______________________
Address ______________________	Address ______________________
City/state/zip ______________________	City/state/zip ______________________
Phone ____________ FAX ____________	Phone ____________ FAX ____________

I will review the records at MDMC   I will pickup copies at MDMC   Send copies to the above address

Identification and proof of authority to request must be presented at the time of request

Legal Authority of person authorizing release of Health Information ___patient ___representative/medical power of attorney
___ parent or guardian of minor ___ administrator of deceased estate Other:

Signature ______________________ **Date** ______________

I authorize MDMC to disclose the identified information to the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge MDMC from any liability and will hold MDMC harmless for any release made pursuant to this Authorization. Unless revoked In writing, this Authorization will expire 90 days from the date of my signature.

<u>I understand</u>: This authorization is voluntary, I may refuse to sign it. MDMC may NOT require that I sign this Authorization to receive treatment except for the provision of research–related treatment on receipt of an authorization for the use or disclosure of PHI for such research; or the provision of health care created solely for the purpose of disclosure to a third party. Any disclosure of information carries with it the potential for an unauthorized re–disclosure and the information may not be protected by federal confidentiality rules. The hospital has 30 days to respond to this request if the records are stored on site, and 60 days if the records are stored off site. If I wish to have copies of records made, then MDMC will assess a fee for copying the recordst which has been set by Missouri law. MDMC will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs. I will be provided a copy of this Authorization after I sign it. I have the right to revoke this authorization at any time by notifying MDMC in writing. If I do, it will *not* have any effect on any actions taken prior to receiving the revocation. I may request to inspect or copy the information that Missouri Delta Medical Center intends to disclose.

VERIFICATION – FOR MDMC USE ONLY

A. ☐ Identity ofrequesting person was verified.   B. ☐ Authorization to request was verified by identification or legal instrument

______________________   ______________________

MDMC employee witness of A and B above   Date

Attach copy of Authorization to Request