FREEMAN Health System

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: _____

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

Physician Office ↓

[ ] _____

[ ] _____

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: _____ E-mail _____

Address: _____ Phone: _____

City/State: _____ Zip Code: _____ Fax (healthcare provider 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
[ ] Complete Billing

[ ] **Other**: _____

Covering the period of health care from:

[ ] Specific Date(s): _____ to _____

Purpose for requesting information:

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

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

[ ] US Mail - paper format
[ ] CD - Secure electronic format
[ ] Fax (to healthcare provider only)
[ ] Pick up copies in the Department
[ ] E-mail

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, HIV related conditions, and or reproductive health information. 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

MAIL TO: FREEMAN HOSPITAL
ATTN: MEDICAL RECORDS
1102 W 32ND STREET
JOPLIN,MO 64804

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