Hannibal Regional Healthcare System

Medical Record Number _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD AND BILLING INFORMATION

*Name of Patient:*_____ *Date of Birth:*_____
Number to call (_____) _____–_____ Call when ready? (circle) yes no (circle) Confidential Fax Mail Pick–up
*Date of Request:*_____ *Date Needed:*_____ *Number to fax (_____) _____–_____*

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

RECORDS COMING FROM:
❑ HRHS
❑ HRH Home Health
❑ Hospice of Northeast Missouri
c/o Health Information Management
Telephone: 573–248–5401 Fax: 573–248–5419

RECORDS GOING TO:
Name:_____
Address:_____
City:_____State:_____ Zip:_____
Telephone:_____ Fax:_____
Email:_____

The type of information to be used or disclosed is as follows (*check all of the appropriate boxes and details as needed):*

Dates of Service/Treatment (include specific dates or date range):_____

❑ Entire Medical Record for Dates Listed
❑ Abstract
❑ Laboratory and Pathology
❑ Cardiology Reports (EKG, ECHO, Cath, etc.)
❑ X–ray Reports
❑ X–ray Films
❑ Therapy Notes (PT, ST, OT, Radiation, etc.)
❑ Immunization Records
❑ Mental Health Records
❑ Itemized Bill
❑ Psychotherapy Notes (Requirements May Apply)
❑ Workability or School Release forms
❑ Physical Forms

Substance Use Disorder records including identity, diagnosis, prognosis and/or treatment are not covered by this form. However, I understand the information in my medical record to be released may include other information ("Sensitive Information") relating to drug or alcohol abuse, behavioral or mental health services (excluding psychotherapy notes), or communicable diseases including human immunodefieciency virus (HIV) and acquired immune deficiency syndrome (AIDS).
Initial HERE if you do NOT wish the Sensitive Information included. _____.

I understand photo identification may be required to obtain medical records.

The purpose for which this disclosure is being made is:
❑ My personal records
❑ Sharing with other healthcare providers
❑ Other (*please describe*) _____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation the the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to the authorization.

NOTE: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of information without specific written consent of the individual whose information is being disclosed or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. I understand that once the above information is disclosed, it may be re–disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that this authorization will expire one year from the date of signature. If I wish the authorization to expire sooner, that date is _____

I understand that if I refuse to disclose all or some healthcare information this may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance, or other adverse consequences. I understand I may have a copy of this release form upon request.

I have read the above information and authorize the above mentioned organization to release the identified information to the persons and for the purpose described above. I understand by signing this document, I release the health care facility from any liability for any release made in compliance with this Authorization.

_____ _____ _____ _____
Witness *Date* *Signature of Patient or Legal Representative* *Date*

_____
Witness Printed Name

_____ _____ Legal Representative Relationship (POA) _____
Minor Age 12 to 17 *Date*
Signature of Patient or Legal Representative