Phelps Health - Health Information Management
1000 West 10th Street
Rolla, MO 65401
HIM Email: HIMCorrespondence@phelpshealth.org
HIM Phone: (573) 458-7550 | HIM Fax: (573) 458-8395

*****For Internal Use Only*****
Date Processed: _____ **By:** _____
Identification Verified: ☐ **Yes** ☐ **No**
☐ **Faxed** ☐ **Mailed** ☐ **Picked up** ☐ **Emailed**
M#: _____

Authorization for Release of Information

Unit: _____ Unit fax: _____
Clinic: _____ Clinic phone/fax: _____

Patient's Name: _____ Patient's Birth Date: _____

Address: _____ City/State/Zip Code: _____ Phone: _____

☐ **I authorize Phelps Health/Phelps Health Medical Group/Phelps Health Homecare to release protected health information (PHI) to:**

_____
Specify to whom PHI is authorized to be released

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include Area Code)

☐ **I authorize Phelps Health/Phelps Health Medical Group/Phelps Health Homecare to obtain protected health information (PHI) from:**

_____
Specify from whom PHI is authorized to be requested

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include Area Code)

Provide copy of my PHI to me by the method I specified below:
☐ Mail ☐ Fax ☐ Pick-up ☐ Release to MyChart web portal
☐ Secure e-mail to the following e-mail address: _____

Date(s) of service for which PHI is being requested:
From _____ **To** _____ ☐ Any and all dates of service
*Indicating **"any and all"** means that records to be released will include all records through the date the patient or patient's representative signs this Authorization as long as the Authorization is not expired or revoked*

PHI to be released:
☐ Office Notes Specific Clinic/Provider: _____
☐ Emergency Room
☐ Immunization/Injection Records
☐ Allergy Records
☐ Billing/Payments
☐ Operative Report
☐ Laboratory Result
☐ Prescriptions
☐ Consultations
☐ Progress Notes
☐ Radiology Reports/Images
☐ History and Physical
☐ Treatments
☐ Discharge Summary
☐ Abstract
☐ Surgical Reports
☐ All Medical Records
☐ Other (please specify): _____

If the PHI authorized for release contains information about substance use disorder, mental health treatment, genetic information, sexually transmitted diseases, HIV/AIDS testing or treatment, or any other sensitive information, I understand that by signing this authorization, I authorize the release of such information unless I list specific exceptions here: _____

Purpose of request *(must check one)*:
☐ Continuing Care: (Specify) _____
☐ Litigation ☐ At the request of the patient
☐ Insurance: (Specify) _____
☐ Other: (Please Explain) _____

Expiration Date or Event: This Authorization will expire 12 months from the date of my signature below unless I revoke this Authorization or unless I otherwise specified here: _____

* I understand that I may revoke this authorization at any time by WRITTEN REQUEST submitted to Phelps Health - Health Information Management at the address above and the revocation will be effective upon receipt of this request by Phelps Health except to the extent that action has already been taken in reliance on this Authorization
* I further authorize that a photocopy, electronically transmitted version or facsimile of this authorization will be treated in the same manner as the original.
* I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.
* I understand that I do not have to sign this Authorization and that treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization.

_____ _____ _____
Signature of Patient/Legal Guardian/Personal Representative Date Time

_____
Relationship, if not the patient

If this Authorization is signed by the patient's personal representative: Please specify below the personal representative's authority to act on behalf of the patient and attach supporting documentation. _____

Phelps Health

Authorization to Release Protected Health Information