Phelps Health Medical Center
1000 West 10th Street
Rolla, MO 65401
(573) 458-8899

Health Information Management
Phone: (573) 458-7550
Fax: (573) 458-8395

*****For Internal Use Only*****
Date Processed: _____ **By:** _____
Driver License Verified: ☐ **Yes** ☐ **No**
☐ **Faxed** ☐ **Mailed** ☐ **Picked Up**
M#: _____
H#: _____

Authorization for Release of Information

Patient's Name: _____ Birth Date: _____
Address: _____ Soc Sec #: _____
City/State/Zip: _____ Phone: _____

☐ I authorize Phelps Health Medical Center to **release information to:**

Print Name / Hospital / Clinic / Doctor / Other

Address

City, State, Zip Code

Phone # / Fax # (include Area Code)

Date(s) Of Service Requesting:

AND/OR

☐ I authorize Phelps Health Medical Center to **obtain information from:**

Print Name / Hospital / Clinic / Doctor / Other

Address

City, State, Zip Code

Phone # / Fax # (include Area Code)

Date(s) Of Service Requesting:

☐ Mail ☐ Fax ☐ Pick-Up

Information to be released:
☐ All Medical Records ☐ Operative Report ☐ **Other:** _____ ☐ Discharge Summary
☐ Emergency Room ☐ Laboratory Result ☐ Radiology Report/Images ☐ History and Physical ☐ Abstract

The following records will not be released unless I initial:
_____ Psychiatric / Mental _____ Chemical Dependency _____ References to AIDS/HIV

Information released will be used for:
☐ Continuing Care: (Specify) _____ ☐ Insurance: (Specify) _____
☐ Litigation ☐ Personal ☐ Other: (Please Explain) _____

* I understand that I may revoke this authorization at any time by WRITTEN REQUEST.
* I understand that the revocation will not apply to information already released in response to this authorization.
* I further authorize that a photocopy or facsimile of this authorization will be treated in the same manner as the original.
* I understand that this authorization will expire six (6) months from the date of my signature unless otherwise specified.
* I understand that this authorization is not valid for future dates of service.
* If you are signing on behalf of patient for whom you are legally responsible, you must present appropriate certification.
If you are signing on behalf of a deceased patient, you must complete an Authorization for Release of Deceased Patient's Health Information.

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

_____ _____
Relationship Witness

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law 42C.F.A, Part 2. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.
The general authorization for the release of medical or other information is not sufficient for this purpose.