Phelps Health Medical Center
Health Information Management
1000 West 10th Street
Rolla, Missouri 65401
Phone: (573) 458-7550
Fax: (573) 458-8395

FOR INTERNAL USE ONLY

Date Received: _____ By: _____

Driver's License Verified ☐ Yes ☐ No

Signature Verified ☐ Yes ☐ No

M# _____

H# _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO PHELPS HEALTH PASSPORT

PLEASE PRINT LEGIBLY

Patient's Name: _____ Birth Date: _____

Address: _____ Soc Sec #: _____

City/State/Zip: _____ Phone #: _____

E-mail Address: _____

THE FOLLOWING STATEMENT MUST BE INITIALED FOR THE AUTHORIZATION TO BE PROCESSED:

_____ Initial

I understand that the following information may be released to my Phelps Health Passport patient portal account if it is contained in my record: Psychiatric/Mental Health, Drugs/Alcohol, and AIDS/HIV and related treatment.

I authorize Phelps Health to release my medical information to my Phelps Health Passport patient portal account.

* I understand that I may terminate my account to Phelps Health Passport at anytime by completing a termination 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 must be executed within six (6) months from the date of my signature.
* If you are signing on behalf of the patient for whom you are legally responsible for, you must present appropriate certification.

_____ _____ _____

Signature of Patient/Legal Guardian/Personal Representative Date Time

_____

Relationship, if not the patient