Phelps Health
MEDICAL GROUP
1050 W. 10th Street
Rolla, MO 65401
P: 573-364-9000

For Internal Use Only
Date Received:_____By: _____
Rcvd Via: ☐ Fax ☐ Mail ☐ Email ☐ Person
Date Processed:_____ By:_____
Identity Verified: ☐ Photo ID ☐ Signature
Sent Via: ☐ Fax ☐ Mail ☐ Email ☐ Person

Authorization for Release of Information

☐ **I authorize Phelp Health Medical Group to Release Information**

☐ **I authorize Phelps Health Medical Group to Obtain Information**

Patient Name: _____ Birth Date: _____

Address:_____ Soc Sec #: _____

City/State/Zip: _____ Phone: _____

Release Information To:

Print Name/Hospital/Clinic/Doctor/Other

Address

City, State, Zip Code

Phone # / Fax # (include Area Code)

Obtain Information From:

Print Name/Hospital/Clinic/Doctor/Other

Address

City, State, Zip Code

Phone # / Fax # (include Area Code)

Information to be: ☐ Mailed ☐ Faxed ☐ Emailed ☐ Picked-up ☐ Viewed Only

Information to be Released:

From (Date)

To (Date)

Specific Clinic/Physician/Provider

Check all that apply:

☐ All Medical Records (Mail Only) ☐ History & Physical ☐ Progress Notes ☐ Consultations
☐ Radiology Reports/Images ☐ Laboratory Results ☐ Surgical Reports ☐ Treatments
☐ Immunization/Injection Records ☐ Prescriptions ☐ Allergy Records ☐ Billing/Payments
☐ Other: _____

The following records will not be released unless I initial:

_____Psychiatric/Mental Health _____Chemical Dependency _____References to AIDS/HIV

Information released will be used for:

☐ Medical Care ☐ Insurance ☐ Legal Investigating/Action ☐ Personal ☐ Other:_____

- 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 in one (1) year from the date of my signature unless otherwise specified.
- I understand that this authorization is not valid for future dates of services.
- I understand that this request may be entitled to a reasonable fee for the retrieval and copying of records.
- If you are signing on behalf of a patient for whom you are legally responsible, you must present appropriate certification.

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.