MISSOURI DELTA
MEDICAL CENTER

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

You have a right to review our Notice of Privacy Practices before signing this Authorization.

Information checked below is requested for: Patient: _____ **DOB:** _____

SSN: _____ **for records created between the dates** _____ **&** _____

Information to be Released

___ Entire Record (except research records and psychotherapy notes) ___ Summary of health information ___ Surgical Reports
___ X−rays ___ Test Reports ___ Photographs/films ___ Complete Medication History
Other: _____

This authorization: (check each category that applies)

Includes ___ **Excludes** ___ HIV/AIDS Test Results and Treatment Records
Includes ___ **Excludes** ___ Mental Health Care Records (except psychotherapy notes)
Includes ___ **Excludes** ___ Drug/Alcohol Treatment Records

Purpose of use & disclosure: ___ self ___ transfer of care ___ present care ___ specialist other: _____

Release Information From	**Send Information to**
Name _____	Name _____
Address _____	Address _____
City/state/zip _____	City/state/zip _____
Phone _____ FAX _____	Phone _____ FAX _____

Identification and proof of authority to request must be presented at the time of request

Legal Authority of person authorizing release of Health Information ___ patient ___ representative/medical power of attorney
___ parent or guardian of minor ___ administrator of deceased estate ___ Other:

I authorize MDMC to disclose the identified information to the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge MDMC from any liability and will hold MDMC harmless for any release made pursuant to this Authorization. Unless revoked In writing, this Authorization will expire 90 days from the date of my signature.

I understand: This authorization is voluntary, I may refuse to sign it. MDMC may NOT require that I sign this Authorization to receive treatment except for the provision of research−related treatment on receipt of an authorization for the use or disclosure of PHI for such research; or the provision of health care created solely for the purpose of disclosure to a third party. Any disclosure of information carries with it the potential for an unauthorized re−disclosure and the information may not be protected by federal confidentiality rules. The hospital has 30 days to respond to this request if the records are stored on site, and 60 days if the records are stored off site. If I wish to have copies of records made, then MDMC will assess a fee for copying the recordst which has been set by Missouri law. MDMC will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs. I will be provided a copy of this Authorization after I sign it. I have the right to revoke this authorization at any time by notifying MDMC in writing. If I do, it will *not* have any effect on any actions taken prior to receiving the revocation. I may request to inspect or copy the information that Missouri Delta Medical Center intends to disclose.

Signature _____ **Date** _____

VERIFICATION − FOR MDMC USE ONLY

A. ☐ Identity of requesting person was verified. B. ☐ Authorization to request was verified by identification or legal instrument

_____ _____

MDMC employee witness of A and B above Date

Attach copy of Authorization to Request