AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

1. **I hereby authorize Bothwell Regional Health Center to:**
   601 E. 14th St. Sedalia, MO 65301
   Phone: 660.827.9590 Fax 660.827.6804 (HIM)

   ☐ **Release to:** ☐ **Obtain from:**

   Name/Facility _____ **Phone:** _____

   Address _____ **Fax:** _____

   City/State/ Zip _____

   The following information from the medical records of

   _____ _____
   Patient's Name Date of Birth

   _____ _____
   Date(s) of Treatment Medical Records #

2. **Information to be released: (Payment of a fee may be required before release of the following information.)**
   - ☐ History & Physical Exam
   - ☐ Emergency Room Report
   - ☐ Face Sheet
   - ☐ Operative Report(s)
   - ☐ Pathology Report(s)
   - ☐ Vaccinations/Immunizations/TB test
   - ☐ Other – Specify
   - ☐ Physician Orders
   - ☐ Physician Notes
   - ☐ Nursing Notes
   - ☐ Physical Therapy
   - ☐ Laboratory Data
   - ☐ Discharge Summary
   - ☐ Consultation by Dr._____
   - ☐ Radiology Reports
   - ☐ Radiology Images - Nuance Cloud or CD
   - ☐ EKG/Cardiology Report

   _____

3. **The above information released is for the following purpose and that purpose only.**
   ☐ Continuation of Care ☐ Legal Purposes ☐ Insurance Purposes ☐ Employer Requirement
   ☐ Personal Reasons ☐ Other_____

4. **I understand** that the information disclosed may contain testing or treatment information relating to Drug and/or Alcohol Abuse; HIV/AIDS virus; Sexually Transmitted Disease; Mental Health Treatment or Psychiatric Treatment.
5. **Revocation Process**: **I understand** that I may, by placing my request in writing to the Bothwell Regional Health Center Privacy Officer, revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Unless revoked this authorization will expire upon release of the information for the purpose stated above.
6. Bothwell Regional Health Center may NOT require you sign this Authorization to receive treatment.
7. **Photocopy: I further authorize** that a photocopy of this authorization form will be fully acceptable as an original and that Bothwell Regional Health Center may deny the release of protected health information if it has reason to believe this authorization has been altered or is not a true and accurate authorization initiated by the patient.

REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary**. I understand** that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by Federal privacy rules.

PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is 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. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Patient's Signature (Photo identification may be required) Date/Time

_____ / _____ _____
Signature of Other Authorized Individual Relationship to Patient Witness

I desire a copy of this release for my records ☐ Yes ☐ No **Initials of Signer**_____
Information has been released by _____ per authorization on _____
Date/Time