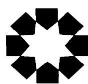

Hannibal Regional Healthcare System

Medical Record Number ________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*Name of Patient:*____ *Date of Birth:*_________________
Number to call (_____) _____–________ Call when ready? (circle) yes no *(circle) Confidential Fax Mail Pick–up*
*Date of Request:*___________________ *Date Needed:*___________________ *Number to fax (_____) _____–__________*

I authorize the use or disclosure of the above named individual's health information, its employees and agents, to furnish:

RECORDS COMING FROM:

❑ Hannibal Reg Hosp ❑ Complete Fam Med
❑ Hannibal Reg Med Group ❑ HRH Home Health
c/o Health Information Management
Telephone: 573–248–5401 Fax: 573–248–5419

RECORDS GOING TO:

Name:____
Address:____
Telephone:____________________ Fax:_____________________
Email:____

The type of information to be used or disclosed is as follows (*check all of the appropriate boxes and details as needed):*
Dates of Service/Treatment (include specific dates or date range):____

HOSPITAL SETTING

❑ Continuing Care Abstract (includes all Physician dictation & Radiology, Lab and Cardiology reports)
❑ Discharge Summary
❑ History and Physical
❑ Consultations
❑ Operative Reports
❑ Emergency Department Records
❑ Laboratory and Pathology Reports
❑ Cardiology Reports (*EKG, ECHO, Cath, etc*)
❑ X–ray Reports
❑ X–ray Films
❑ Therapy Notes (*PT, ST, OT, Radiation, etc*)
❑ Mental Health Records
❑ Psychological Testing
❑ Clinic Notes (*Wound, Pain*)
❑ Itemized Bill
❑ Entire Record for dates listed

❑ Other (*please specify*):____

OFFICE SETTING

❑ Office Notes
❑ Laboratory Reports
❑ Itemized Bill
❑ Immunization Records
❑ Physical Forms
❑ Mental Health Records
❑ Entire Record for dates of service
❑ Workability or School Release forms

❑ Other (*please specify*):____

I understand that the information in my health record to be released may include information relating to drug or alcohol abuse, behavioral or mental health services (excluding psychotherapy notes), or communicable disease including human immunodefieciency virus (HIV) and acquired immune deficiency syndrome (AIDS). A request in writing must be made to exclude the above from the disclosed information.

I understand photo identification may be required to obtain medical records.

The purpose for which this disclosure is being made is:
❑ My personal records
❑ Sharing with other healthcare providers
❑ Other (*please describe*) ____

I understand that I have the right to revoke this Authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation the the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to the authorization.

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of information without specific written consent of the individual whose information is being disclosed or as otherwise permitted by law. A general authorization for the rele of medical or other information is NOT sufficient for this purpose. I understand that once the above information is disclosed, it may be re–disclosed by the recipient an the information may not be protected by federal privacy laws or regulations.

I understand that this authorization will expire one year from the date of signature.

I understand that if I refuse to disclose all or some healthcare information this may result in improper diagnosis or treatment, denial of coverage or claim for health bene or other insurance, or other adverse consequences. I understand I may have a copy of this release form upon request.

I have read the above information and authorize the above mentioned organization to release the identified information to the persons and for the purpose described above. I understand by signing this document, I release the health care facility from any liability for any release made as a result of the Authorization.

_________________________________ ___________ _____________________________________ ___________
Witness *Date* *Signature of Patient or Legal Representative* *Date*

_________________________________ ___________ Legal Representative Relationship (POA) ______________________
Minor Age 12 to 17 *Date* *Signatur of Patient or Legal Representative* *Date*