Processed by_____ (initials) Requesting Provider_____

Authorization for Use and Disclosure of Protected Health Information
Community Health Center of Central Missouri
Phone: (573) 632-2777 Fax: (573) 632-2769

Patient Name:_____
(Last) (First) (MI)
Date of Birth:_____-_____-_____ Former Name:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize Community Health Center of Central Missouri
1511 Christy Drive, Jefferson City, MO, 65101 **1016 E. Main, Linn MO 65051**
606 E Buchanan Rd, California MO 65018 **561 Commons Drive, Fulton MO 65251**

To _____ release _____ obtain my protected health information as indicated below via:
(Mark one)□ _____ Mail □_____ Fax □_____ Hold for Pick-up

To/FromName:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

INFORMATION TO BE RELEASED

	Dates		Dates
___Discharge Summary	_____	___ X-Ray Reports/Films	_____
___History/Physical Exam	_____	___Medication Records	_____
___Operative Report	_____	___ Lab/Pathology Reports	_____
___ Dental Records/Xrays	_____		

___Other:_____

PURPOSE OF DISCLOSURE (Circle One)

□

Changing Providers Legal Consultation Insurance Purposes Other:_____

AKNOWLEDGEMENT OF UNDERSTANDING:

I understand this release of information may include records relating to care and treatment for mental health conditions, care and treatment for dug or alcohol abuse, HIV testing, infections status, care and treatment for AIDS, or information related to genetic testing.

I understand that this authorization will expire in 1 year from the date it is signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extend action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations.

I understand this use or disclosure of information, there will be no conditions placed on my health care of payment for my health care.

I understand my request will be acted upon within 30 days. If I am not provided access or information cannot be supplied, I understand I will be notified, and have the right to request review on and denial of access other than those made in accordance with applicable law.

I understand that I may be required to pay the cost of preparing and mailing copies supervising my inspection, or preparing a summary except for uses and disclosures for the purpose of treatment, payment, and operations.

Patient/Legal Representative

Signature:_____Date:_____Relationship:_____

Witnessed By:_____ Date:_____