CAPITAL REGION MEDICAL CENTER
P.O. Box 1128
Jefferson City, MO 65102-1128

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

1. I hereby authorize Capital Region Medical Center - _____ **to: __ obtain from:**
specify clinic, if applicable **__ release to:**

_____
(Who is to receive the information from Capital Region Medical Center or Who is to send information to Capital Region Medical Center?)

The following information from the medical records of:

_____ _____
Patient's Name - Please PRINT Date of Birth

_____ _____
Treatment Date(s) Social Security Number

2. Information to be released: (Payment of a fee may be required before release of the following information.)

___ History & Physical Examination
___ Discharge Summary
___ Laboratory Data
___ Physician Notes
___ Emergency Room Report
___ Face Sheet
___ Operative Report(s)
___ Pathology Report(s)
___ Physician's Orders
___ Short Stay Form
___ Consultation by Dr._____
___ Radiology Report/X-ray Films (films released only thru Radiology)
___ Nursing Notes
___ EKG/Cardiology Report
___ Clinic Notes for dates: _____
___ Other-specify:_____

3. There are no limitations placed on dates, history of illness or diagnostic and therapeutic information, including any treatment of alcohol use/abuse, drug use/abuse, HIV-AIDS, mental health treatment or psychiatric treatment.
SIGNER MUST INITIAL THIS CLAUSE:_____ OR QUALIFY THE CLAUSE: _____
_____

4. 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:_____

5. Revocation Process: I understand that I may, by placing my request in writing to the Capital Region Medical Center Privacy Officer, revoke this authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization will expire three months from the date of my signature or as otherwise specified by date, event or condition as follows:_____

6. Capital Region Medical Center may NOT require that 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 Capital Region Medical 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.

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

_____ _____
Signature of Other Individual Relationship of Other to 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 confidentiality rules. **SIGNER MUST INITIAL THIS CLAUSE:_____**

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.

I desire a copy of this release for my records ___Yes ___No _____**INITIALS OF SIGNER**

Information has been released per authorization by_____ on date:_____