Print Form

HANNIBAL CLINIC OPERATIONS, L.L.C.

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

P.O. Box 311, Hannibal, MO 63401, Phone: 573/231-3196 Fax: 573/231-3705

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize Hannibal Clinic Operations, L.L.C., to use or disclose the protected health information described below to _____

1. Patient Name:_____

Date of Birth: _____ Social Security #: _____

Address: _____

Home Phone #: _____ Work Phone #: _____

2. Information to be disclosed to: _____

Address: _____

Phone #: _____ Fax #: _____

Appointment Date & Time: _____

3. Information requested from (name of facility): _____

Address: _____

Phone #: _____

4. Authorization for Release of Information covering the period of health care for treatment dates: _____ to _____ OR _____ all past, present and future periods.

____ I hereby **authorize the release of the following records for the date (s) above:**

_____

____ I hereby **authorize the release of my complete health record** (including records related to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

____ I hereby **authorize the release of my complete health record <u>WITH THE EXCEPTION OF</u> the following information:**

_____ Mental health records
_____ Communicable diseases (including HIV and AIDS)
_____ Alcohol/drug abuse treatment
_____ Other (please specify): _____

5. This medical information may be used by the person I authorize to receive this information for the following purposes: _____ medical treatment or consultation, _____ billing or claims payment, or _____ other (specify)_____ as I may direct.

6. This authorization shall be valid for one year from date of signature OR until _____ at which time this authorization expires**.**
(Date of Event)

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that my person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to content a claim.

8. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Information to be _____ mailed _____ faxed _____ Picked up at Front Desk

10. I certify that the information given by me in applying for payment under Title (18) XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Medicare Program and/or the Social Security Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization and request shall apply to the period: _____ to _____.

_____ _____
Signature of Patient or Personal Representative **Date Signed**

_____ _____
(Print name of Patient or Personal Representative) Relationship to Patient

***Records created by another entity outside of Hannibal Clinic L.L.C. must be requested from the entity that created the Item. Requests are released according to the Hannibal Clinic L.L.C. Health Record definition.**

Processing and handling fees may apply pursuant to RS MO 191.227. There will be a charge for copies or transfers of x-ray films.
Information released per authorization

By: _____

Date: _____

Revised 06/15/2010