Hannibal Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name (Please Print): _____ **DOB:** _____/_____/_____

Mailing Address: _____

SSN: _____ **Phone Number:** _____ **Records to be received via:** ❒ Pick Up ❒ Mail ❒ Fax

Date of Request: _____ **Date Needed:** _____

I authorize the use or disclosure of the above-named individual's health information as follows:

RECORDS FROM
Facility Name: _____
Provider Name: _____
Address: _____
_____
Telephone: _____ Fax: _____

RECORDS TO BE SENT TO
Facility Name: _____
Provider Name: _____
Address: _____
_____
Telephone: _____ Fax: _____

The type of information to be used or disclosed is as follows *(check all of the appropriate boxes and provide details as needed)*:

Dates of Service/Treatment (include specific dates or date range):
_____

❒ Office Notes ❒ Immunization Records ❒ Entire Record for Dates of Service Listed Above
❒ Laboratory Reports ❒ Physical Forms ❒ Work or School Release Forms
❒ Itemized Bill ❒ Mental Health Records ❒ Other (please specify): _____

*Records created by another entity outside of Hannibal Clinic Operations, LLC must be requested from the entity that created them.
*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.

I understand that the information in my health record may include information relating to sexually transmitted disease, genetic testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services. I DO NOT authorize the release of information relating to:

❒ **Substance abuse (including alcohol/drug abuse)** ❒ **Mental health or behavioral health**
❒ **HIV related information (AIDS-related testing)** ❒ **Physical or sexual abuse**

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

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

The purpose for which this disclosure is being made is:
❒ My Personal Use ❒ Transfer of Care to Another Provider (Name of Provider): _____
❒ Sharing with Other Healthcare Providers Involved in My Care
❒ Other (please specify): _____

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

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. In accordance with 42 CFR Part 2, no person or agency to whom any information is disclosed may re-disclose such information unless the person who consented to the disclosure specifically consents to such re-disclosure. I understand that I have the right to inspect and copy the information that is to be disclosed.

This authorization expires on: _____. If I fail to specify an expiration date, this authorization will expire one (1) year from date of signature.

I understand authorizing the use or disclosure of the information identified above is voluntary. Healthcare treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on signing the authorization. Beyond this, my refusal to consent may have the following consequence: Failure to disclose information. Electronic images/records (ie: radiology) on CD/USB media are not encrypted or password-protected and are the sole responsibility of the recipient of the records to protect from unauthorized viewing. Unencrypted CD/USB media cannot be mailed by Hannibal Clinic Operations, LLC.

X _____ _____ _____ _____
Signature of Patient/Parent/Legal Guardian **Printed Name** **Date** **Time**

Witnessed by: _____ **Date:** _____/_____/_____

This authorization must be signed by the parent or guardian if the patient is less than 18 years of age. If the patient is mentally incompetent and over the age of 18, this authorization must be signed by the appointed legal representative of the patient.

Hannibal Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

GUIDELINES FOR COMPLETING "AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION" FORM

Name of Patient:	Legal name of patient.
Date of Request:	The date information is requested from Hannibal Clinic or the date that Hannibal Clinic is requesting information.
Date Needed:	Only to be used as a guide for Hannibal Clinic on when a requesting party needs the requested information.
Date of Birth:	Patient's date of birth.
FROM:	If we are requesting information from another organization, write name of organization, address, and phone. If organization is requesting information from Hannibal Clinic, write Hannibal Clinic.
TO:	If we are requesting information from other organization, write Hannibal Clinic. If organization is requesting information from Hannibal Clinic, write name of organization.
Date of Service:	Date of records needed, this can be a date range (i.e. "99 to present", or specific lab report on 06/01/01).
Type of Record Requested:	Check the box that applies (i.e. "Mental Health Records").
Sensitive Records:	***THIS LINE MUST BE SIGNED BY THE PATIENT!*** Additionally, patient MUST check the box beside any type of record they wish to be excluded from release; otherwise, records will be released in accordance with HIPAA and SAMHSA legislation. **Again, patient MUST sign this acknowledgement or the release is invalid.**
Purpose:	Check box that applies. "Sharing with other healthcare providers" could be to give or receive information.
Expiration:	Any date can be written here; if left blank, one (1) year will apply.

Completed form should be sent to Health Information Management for processing.

Phone: 573-231-3196
573-231-3176

Fax: 573-231-3705