



Patient Name: _____ Date of Birth: ____/____/____

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

Cell Phone: _____ Home Phone: _____

I request my protected health information from St. Mary's Medical Center – Blue Springs MO

1. Who will we be releasing your protected health information (PHI)/medical records to?

Name: _____

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

2. How would you like the medical records delivered:

- Email: _____
- Faxed to: (____) - ____ - _____
- Pick up in Medical Records
- Mailing Address: _____ City: _____ State: _____ Zip Code: _____

3. Dates of Service _____ Specific Date (s): _____ to _____

4. I authorize the following PHI to be released for

- | | | |
|---|--|--|
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Laboratory Report(s) | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Report(s) | <input type="checkbox"/> Detailed Billing |
| <input type="checkbox"/> Hospital Summary (transcribed reports/lab/radiology) | <input type="checkbox"/> Cardiology Reports | <input type="checkbox"/> Radiology Films |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Pathology Slides |
| <input type="checkbox"/> Consultants | <input type="checkbox"/> Sleep Study Records | <input type="checkbox"/> Cardiovascular images |
| | <input type="checkbox"/> Other: please specify _____ | |

5. Purpose for requesting information:

- Legal
- Insurance
- Personal
- Continuation of Care

6. By signing this authorization form, I understand that PHI may include records relating to mental health, HIV/AIDS, and/or of alcohol/drug abuse.

Patient/Authorized Representative Signature; _____ Date: ____/____/____ Time: _____

Printed name of Authorized Representative: _____ Relationship to Patient: _____

Witness Signature: _____ Date: ____/____/____ Time: _____

- Copy of Photo ID
- Matching Signature
- Other _____

Medical Records Phone Number: 816-655-5418 Fax Number: 816-220-1807

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and Missouri law prohibit you from making any further disclosure of this information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. REV. 04-2018