St. Mary's Medical Center

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Identification

1. Printed Name: ______________________ Date of Birth: ______________________
   Address: ______________________
   Telephone: ______________________
2. **Purpose of Request:** Information will be used/disclosed for the following purpose(s): ______________________

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Person(s)/Facility Authorized to Release Information (From)		**Person(s)/Facility Authorized to Receive Information (To)**	
Name:	St. Mary's Medical Center	3 Name:	______________________
Address:	201 NW R.D. Mize Road	Address:	______________________
Address:	Blue Springs, MO 64114	Address:	______________________

4. **Specify date(s) of care or diagnosis to be released:** ______________________

5. **I Authorize the release of the following information:**
Please check type of information to be released (please check all that apply):

- ☐ History and physical exam
- ☐ Progress notes
- ☐ Discharge summary
- ☐ Consultation reports
- ☐ Laboratory records
- ☐ Emergency records
- ☐ Pathology records
- ☐ Pathology slides
- ☐ Cardiovascular images
- ☐ X-ray films/Other diagnostic images
- ☐ Verbal Information Exchange (Amina Center Only)
- ☐ Complete billing record/itemized bill
- ☐ Entire medical record (excludes records from other providers)
- ☐ Records from other providers (SMMC is neither able or willing to verify the accuracy, completeness, content or authenticity of any medical records prepared or generated by another health care provider)

6. **Drug / Alcohol Abuse, Mental Health and HIV/AIDS Records Release** (In Missouri you must approve the release of this information.)
If my medical or billing record contains information about drug and/or alcohol abuse, mental health, and/or other sensitive information, I agree to its release.

Drugs/Alcohol ☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No Mental Health ☐ Yes ☐ No

7. I authorize the release of: (check one)
- ☐ My medical records created before the date I signed this authorization.
- ☐ My medical records created both before and after the date I signed this authorization.
- ☐ My medical records created after I signed this authorization.

8. **Time Limit / Right to Revoke**
This authorization will expire 1 year from the date of my signature or on the following date or event (please specify):

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If I want to cancel this authorization before it expires, I may submit a written notice to the Director of Medical Records at St. Mary's Medical Center, 201 N.W. R.D. Mize Road, Blue Springs, MO 64014. I understand that I may not revoke my authorization to the extent it was already acted on and information released prior to my written cancellation was made at my request and with my consent.

Re-disclosure
I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. St. Mary's Medical Center, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Signature of Patient or Personal Representative Who May Request Disclosure
I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization and that I can inspect or copy the protected health information to be used or disclosed. **If medical records or correspondence from other providers was released pursuant to this form, we cannot attest to the accuracy or completeness of the information.**

I hereby authorize St. Mary's Medical Center to release the protected health information as specified above.

9. ______________________ 10. ______________________
Signature of Patient or Patient Representative — Date

______________________ ______________________
Print Name of Patient or Patient's Representative — Relationship of Patient Representative (if applicable)

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** ______________________

Verified by: ______________________

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. 2/2007

Instructions: Patient or Patient Representative should be given a copy of the completed form. Place the original in the Medical Record.