Phelps Health
Health Information Management
1000 West 10th Street
Rolla, MO 65401
HIMCorrespondence@phelpshealth.org

Phone: (573) 458-7550
Fax: (573) 458-8395

*****For Internal Use Only*****
Date Processed: _____ **By:** _____
Driver License Verified: ☐ **Yes** ☐ **No**
☐ **Faxed** ☐ **Mailed** ☐ **Picked Up** ☐ **Emailed**
M#: _____

Authorization for Release of Information

Patient's Name: _____ Birth Date: _____

Address: _____ Soc Sec #: _____

City/State/Zip: _____ Phone: _____

☐ I authorize Phelps Health/Phelps Health Medical Group to **release information to:**

_____
Print Name / Hospital / Clinic / Doctor / Other

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include Area Code)

_____
Date(s) Of Service Requesting

AND/OR

☐ I authorize Phelps Health/Phelps Health Medical Group to **obtain information from:**

_____
Print Name / Hospital / Clinic / Doctor / Other

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include Area Code)

_____
Date(s) Of Service Requesting

☐ Mail ☐ Fax ☐ Pick-Up ☐ Release to MyChart ☐ Secure Email to: _____
Email Address

Information to be released:

☐ Office Notes Specific Clinic/Provider: _____
☐ Emergency Room ☐ Operative Report ☐ Progress Notes ☐ Discharge Summary
☐ Immunization/Injection Records ☐ Laboratory Result ☐ Radiology Reports/Images ☐ Abstract
☐ Allergy Records ☐ Prescriptions ☐ History and Physical ☐ Surgical Reports
☐ Billing/Payments ☐ Consultations ☐ Treatments ☐ All Medical Records
☐ Other: _____

The following records will not be released unless I initial:

_____ Psychiatric / Mental _____ Chemical Dependency _____ References to AIDS/HIV

Information released will be used for:

☐ Continuing Care: (Specify) _____ ☐ Insurance: (Specify) _____
☐ Litigation ☐ Personal ☐ Other: (Please Explain) _____

* I understand that I may revoke this authorization at any time by WRITTEN REQUEST.
* I understand that the revocation will not apply to information already released in response to this authorization.
* I further authorize that a photocopy or facsimile of this authorization will be treated in the same manner as the original.
* I understand that this authorization will expire one (1) year from the date of my signature unless otherwise specified.
* I understand that this authorization is not valid for future dates of service.
* I understand that this request may be entitled to a reasonable fee for the retrieval and copying of records.
* If you are signing on behalf of patient for whom you are legally responsible, you must present appropriate certification.
If you are signing on behalf of a deceased patient, you must complete an Authorization for Release of Deceased Patient's Health Information.

_____ _____ _____
Signature of Patient/Legal Guardian/Personal Representative Date Time

_____ _____
Relationship Witness

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law 42C.F.A, Part 2. You are 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.
The general authorization for the release of medical or other information is not sufficient for this purpose.