CoxHealth

Authorization for Use and Disclosure of Protected Health Information

Patient Identification

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ Social Security #: _____

Cox Health Center Willard
304 E Jackson, Bldg B-207
PO Box 186
Willard, MO 65781
(417) 269-2458 Fax (417) 269-2465

Information to Be Released -- Covering the Periods of Health Care

From: _____*(date)* To: _____*(date)*

From: _____*(date)* To: _____*(date)*

Purpose of Request

☐ Treatment or consultation
☐ At the request of the patient
☐ Billing or claims payment
☐ Other: _____

Please check type of information to be released:

☐ Pertinent Documentation	☐ History and physical	☐ X-ray reports	☐ X-ray films/images
☐ Complete health record	☐ Discharge Summary	☐ Photographs, videotapes	☐ EKG
☐ Complete billing record	☐ Operative Report	☐ Lab Results	☐ EEG
☐ Itemized bill	☐ Consultation reports	☐ Progress notes	☐ Other

If Other, (specify) _____

I, the undersigned, authorize and request this facility to: ☐ Release information to ☐ Obtain information from

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information, I agree to its release.

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize redisclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being redisclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Site Privacy Coordinator at the above address. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be redisclosed by the recipient and no longer protected by the federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize CoxHealth to use and disclose the protected health information specified above.**

Signature: _____
(Patient, parent if the patient is a minor child, or guardian) *Date*

Relationship to Patient: _____

Revised April 14, 2004

A copy of this authorization shall be as effective and valid as the original."

Identity of Requester Verified via:

___ **Photo ID, Matching Signature**

___ **Other, specify** _____

Verified by: _____