University Hospital
University of Missouri Health System

University Hospital Medical Records
One Hospital Drive, DC042.00
Columbia, MO 65212
Phone (573) 882-3170
Fax (573) 882-3209

please place patient label here

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment or health care operations. In our Notice of Privacy Practices, we provided you information about how University of Missouri Health System (UMHS) can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this authorization.

Patient Name: _____ DOB: _____ SSN: _____

_____
Address City, State Zip Phone Number

I, _____ hereby authorize UMHS to release my medical records from:
Name of Patient

- ❑ University Hospitals and Clinics to release my records to:
- ❑ Ellis Fischel to release my records to:
- ❑ Columbia Regional Hospital to release my records to:
- ❑ Missouri Psychiatric Center to release my records to:
- ❑ University Physicians Clinic(s) at _____to release my records to:

_____
Name of Person and Entity Receiving Information Phone Number

_____
Address of Person and Entity Receiving Information Fax Number
(records will be faxed for immediate patient care only – all other records will be mailed)

The following information will be released:

Pending Appointment
Date and Time: _____

☐ Admission Note	☐ Operative Report and/or Diagnostic Tests	☐ Discharge Summary
☐ Progress Notes	☐ Consultations	☐ Physicians Orders
☐ Nurses Notes	☐ Emergency Room Report	☐ Ambulance Record
☐ Radiology Reports	☐ Laboratory Reports	☐ Surgical Pathology
☐ Clinic Notes	☐ Autopsy Report	☐ Other:
☐ *Copy of Billing Statement*	☐ *Radiology Films (CD copy)*	☐

Dates of treatment to be released: From: _____ **to** _____**.**

MR012-12-08

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Release of this information is being made for the following purpose: _____
(Describe the reason for the request)

PSYCHIATRIC, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS RECORDS RELEASE:

I understand if my medical or billing record contains information in reference to *psychiatric testing and/or treatment* I agree to its release. Check one: ☐ Yes ☐ No

I understand if my medical or billing record contains information in reference *to drug and/or alcohol abuse*, *sexually transmitted disease*, *Hepatitis B or C testing*, and/or other *sensitive information*, I agree to its release. Check one: ☐ Yes ☐ No

I understand if my medical or billing record contains information in reference to *HIV/AIDS testing and/or treatment* I agree to its release. Check one: ☐ Yes ☐ No

You may request to inspect or copy the information that UMHS intends to disclose. UMHS may NOT require that you sign this authorization to receive treatment. You may refuse to sign this authorization. If you refuse to sign this authorization, the requested information will not be released. Once release of this information is disclosed to the above named person or persons, your information may be subject to re-disclosure by that person or persons. You may revoke this authorization at any time, except to the extent that we have already released information in reliance on this authorization. Typically, this is accomplished on our Revocation Form, but alternative means of notice are acceptable. Unless you revoke this authorization, this authorization will expire on the following date or condition_____. If you do not fill out a specific date or condition upon which this authorization will expire, it will automatically expire six months from the date of your signature.

If you are requesting information for yourself or for a third party, UMHS may assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all applicable Missouri state and federal laws.

I, _____, have read the above information and authorize UMHS to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document, I release and discharge UMHS from any liability and will hold UMHS harmless for any release made pursuant to this authorization. A copy of this authorization will be available to you after you sign it.

_____ _____
Signature of Patient or Legal Representative[1] Date

[1]If signed by the Legal Representative, he or she should describe the nature of his or her authority to sign for the patient and attach a copy of the documentation.

[If you are obtaining an authorization for disclosure of PHI created for research purposes, please contact the Institutional Review Board (IRB), as such an authorization requires detailed information beyond the scope of this document.]

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