OZARKS HEALTHCARE

Patient Label

Authorization to use and/or release protected health information

Patient Name: _____ **DOB:** _____

Address: _____

Phone #: _____ Cell or Work #: _____ **MR #:** _____

1) I authorize: OzH/BHC to disclose my health information specific to the following dates and/or time period: Valid for 12 months from date signed below

2) Person(s) or Entity(ies) authorized to receive my health information: _____

Address: _____ Phone #: _____

3) **Purpose for Disclosure:** ☒ Continuity of Care ☐ Personal ☐ Legal ☐ Insurance ☐ School
☐ Other _____

4) Information to be Disclosed/Released:

Hospital Records:

☐ Consultation(s) ☐ Copy(ies) of Imaging on CD ☐ Discharge Summary ☐ Emergency Room Record(s)
☐ EKG (s) ☐ GI-Lab Procedures ☐ History & Physical Exam ☐ Immunization Record(s)
☐ Laboratory Report(s) ☐ Medication List(s) ☐ Operative Report(s) ☐ Pathology Report(s)
☐ PFT Study ☐ Problem List(s) ☐ Radiology Report(s) ☐ Sleep Study
☐ Stress Test(s) ☐ 2Way Verbal Exchange of Info ☐ Other: _____

Out-Patient Clinic Records:

☐ PT Evaluation ☐ OT Evaluation ☐ SLP Evaluation ☐ Daily Treatment Notes ☐ Discharge Summary
☐ Flow Sheet(s) ☐ Immunization Record ☐ List of Allergies ☐ Medication List(s) ☐ Problem List(s)
☐ Progress Note(s) ☐ Progress Report(s) ☐ Summary Letter(s) ☐ Other: _____
☒ Two-Way Verbal Exchange of Information between: OzH/BHC and _____

I understand that IF CHECKED AND INITIALED this will include health information relating to:

☐ HIV (Human Immunodeficiency Virus) Infection _____ ☑ Mental Health Records _____ Initial
Initial ☑ Treatment of Alcohol and/or drug abuse _____ ☐ Genetic Testing _____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol & Drug Abuse Patient Records, 42 CFR Part 2, and cannot be dislocated without my written consent unless otherwise provided for in the regulations.

5) I understand that if the person(s) or entity(ies) that receive the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release ***Ozarks Healthcare its employees and my physicians***, from all liability arising from this disclosure of my health information.

6) **I also understand that a fee for copying these records may apply.** N/A (patient/guardian initials)

7) It is my understanding that this authorization will expire in six (6) months from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Health Information Management Department or appropriate clinic or physician's office, knowing that previously disclosed information would not be subject to my revocation request.

8) I understand that authorizing the disclosure of this health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

9) **I understand and agree that the information may be released in an encrypted format**

10) **I would like my records to be in a Digital format. (on CD) Initials** _____

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_____ Signature of Patient or Legal Representative — _____ Date — _____ Time

_____ Printed Name if Signed on Behalf of the Patient — _____ Relationship

_____ Signature of Witness — _____ Date — _____ Time