ROI

CoxHealth
Springfield, MO

Patient Name _____
Patient # _____
Date of Service _____
(or use patient label)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____

_____

Social Security #: _____ Telephone: _____

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

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please check type of information to be released:

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

Other, (specify) _____

Purpose of Request

___ Treatment or consultation ___ At the request of the patient ___ Billing or claims payment

Other, (specify) _____

I, the undersigned authorize and request CoxHealth to ___Release information to ___ Obtain information from

Name: _____

Address: _____

_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, 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 facility Privacy Officer at [3801 S National, Springfield MO 65807]. 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 re-disclosed by the recipient and no longer protected by 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: _____ **Date:**___/___/___
(*Patient, parent if minor child, or legal guardian)*

Relationship to Patient: _____

Original: Facility Photocopy: Patient

(Office Use only) Identity of Requester Verified via:

____ Photo ID, Matching Signature

____ Other, Specify _____

Verified by: _____