Health Care

MRN: _____

Visit: _____
For Office Use Only

University Hospital, Health Information Services
One Hospital Drive, DC042.00
Columbia, Missouri 65212
roiu@health.missouri.edu
Phone (573) 882-3170 Fax (573) 882-3209

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 most uses and disclosures 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 Care (MUHC) 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 last 4 digits _____

Address _____ City, State, Zip Code _____ Phone Number _____

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

- ☐ All locations to:
- ☒ Student Health Center to:
- ☐ Ellis Fischel Cancer Center to:
- ☐ Women's & Children's Hospital to:
- ☐ Missouri Psychiatric Center to:
- ☐ University Hospitals, Physicians, and Clinic(s) at _____ 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)

Pending Appointment Date/Time: _____

The following information will be released:

☐ Admission Note	☐ Operative Note	☐ Discharge Summary
☐ Clinic Notes	☐ Consultations	☐ Progress Note
☐ Emergency Room Record	☐ Ambulance Record	☐ Laboratory Reports
☐ Diagnostic Testing	☐ Radiology Reports	☐ Radiology Films (CD Copy)
☐ Pathology Slides/Tissue Blocks & Related Reports	☐ Copy Of Patient's Bill	☐ Verbal Communication With: _____

☒ Other: Immunizations, TB treatment records, TB testing, CXR, Labs- Urine drug screen, QFT, antibody titers

Dates of treatment to be released – From: BIRTH to SIX MONTHS FROM TODAY

Release of this information is being made for the following purpose:

☐ Medical ☐ Disability ☐ Insurance ☐ Personal Use ☒ Other: Compliance for school program

I would like my medical records released in ☐ Paper Copies ☐ Electronic format (CD Copy)

☒ E-Mail, I understand by initialing here, _____ that standard email services, such as Gmail and other private Email providers, are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals. Having been informed of the risks associated with non-secure email communications, I accept the risks and request to have my medical records sent via the following email address:

_____

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Initials required in section below. If not initialed, such records will not be released.

MENTAL HEALTH, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS RECORDS RELEASE:	**Initials**
I understand if my medical record or billing record contains information in reference to *mental health testing and/or treatment,* I agree to its release.	
I understand if my medical record 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.	
I understand if my medical or billing record contains information in reference to *HIV/AIDS testing and/or treatment*, I agree to its release.	

You may request to inspect or copy the information that MUHC intends to disclose. MUHC 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 (with written notice to Medical Records at the address above), except to the extent that we have already released information in reliance on this authorization. Typically, revocation may be accomplished by our Revocation Form, but alternative means of written 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.

MUHC may assess appropriate and reasonable fees for the copy of such information. Such fees will comply with all applicable Missouri state and federal laws.

I, _____ have read the above information and authorize MUHC to disclose the identified information to the persons and for the purpose described herein. A copy of the authorization will be provided upon request.

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

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

Patient is: ☐ Minor ☐ Deceased ☐ Incompetent

Relationship to the patient: ☐ Parent ☐ Legal Guardian ☐ Conservator ☐ Power of Attorney ☐ Other: _____

If you are obtaining an authorization for disclosure of Protected Health Information (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. IRB phone number is (573) 882-3181.