Putnam County Memorial Hospital (PCMH) and Rural Health Clinic (RHC)

1926 Oak Street, PO Box 389, Unionville, MO 63565
PCMH Phone: 660-947-2411; **Fax** 660-947-3089 **RHC Phone** 660-947-2425; **Fax** 660-947-7024

AUTHORIZATION For ACCESS to and/or RELEASE OF PROTECTED HEALTH INFORMATION (Please circle one)

As set forth more fully in our Notice of Privacy Practice, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment, health care operations, or other specific uses or disclosures permitted or required by law. In our Notice of Privacy Practices, we provided you information about how Putnam County Memorial Hospital and Rural Health Clinic can use or disclose your information. You have the right to review our Notice of Privacy Practices before signing this authorization.

I hereby authorize PCMH and/or RHC to either ACCESS and/or RELEASE my protected health information as described below:

Patient Name	Social Security #	Date of Birth	Medical Record #
_____	_____	_____	_____

☐ I am requesting to have the following health information **COPIED**, and I will pick them up at Putnam County Memorial Hospital and/or Rural Health Clinic.

☐ I am requesting that Putnam County Memorial Hospital/Rural Health Clinic copy the following health information and **SEND** the requested records to the following individual(s) and/or address below.

☐ I am requesting to **REVIEW** my health information at Putnam County Memorial Hospital and/or Rural Health Clinic.

Name & Address of Person(s) to receive the records (Please include any pertinent phone or fax numbers)

_____

I am requesting the following protected health information that was created between ____/____/____ and ____/____/____.

____ Discharge Summary	____ Lab Report(s)	____ Emergency Room Record
____ History & Physical	____ Radiology Report(s)	____ RHC Office Visit
____ Consultation Report	____ Radiology CD	____ Princeton Office Record
____ Operative Report	____ Respiratory Report	____ EKG Report
(Please initial below)		____ Other: _____

☐ I authorize the release of any information created on or between the above dates relating to psychiatric treatment/testing.

☐ I authorize the release of any information created on or between the above dates relating to treatment of drug or alcohol abuse.

☐ I authorize the release of any information created on or between the dates relating to information concerning AIDS/HIV treatment/testing, if any, including the test results thereof, history of illness, and/or diagnostic information.

Purpose for which the protected health information will be used: _____

Putnam County Memorial Hospital and/or Rural Health Clinic may NOT require that you sign this Authorization to receive treatment. You may refuse to sign this Authorization. You may inspect or obtain a copy of the information to be disclosed. Once this information is released and/or received, your information may be subject to redisclosure by the above person(s) and/or facility. You may revoke this Authorization in writing at any time, except to the extent that we have already released and/or received information in reliance to this Authorization. Unless you revoke this Authorization in writing, this Authorization will expire in **(90) days** from the date it was signed or upon expiration of the event for which Authorization was requested.

☐ **(please initial)** If you are requesting information for yourself or for a third party, Putnam County Memorial Hospital and/or Rural Health Clinic may assess appropriate fees for the copying of such information. Such fees will comply with all applicable state and federal laws. A copy of this authorization will be provided to you after signing it.

I, _____ , have read the above information and authorize Putnam County Memorial Hospital and/or Rural Health Clinic to disclose the identified information to the above named person(s) and/or facility and for the purpose described herein. I understand that by signing this document, I release and discharge Putnam County Memorial Hospital and Rural Health Clinic from any liability and will hold Putnam County Memorial Hospital and Rural Clinic harmless for any release made pursuant to this Authorization.

Signature of Patient/Legal Guardian and/or Representative	**Date**	**If not patient, State Relationship or Legal Authority**	**Date**
_____	_____	_____	_____

OFFICE USE ONLY Disclosure Logged: ___ Yes ___ No

FORM COMPLETED BY: _____ _____ Date: _____ Employee Initials: _____