

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION  
ACCESS REQUEST TO ANOTHER AGENCY**

more than health care ... life care

**MOSAIC™**  
LIFE • CARE

myMosaicLifeCare.org

MRN: \_\_\_\_\_ Job/RR#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Name at time of treatment if different from above: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

**I request my protected health information  
(PHI) be released from:**

- Medical Center- Albany (hospital)
- Medical Center- Maryville (hospital)
- Medical Center- Saint Joseph (hospital)
- Long Term Acute Care Hospital (LTACH)
- Clinic Name/Please Specify: \_\_\_\_\_

**I request my protected health information  
(PHI) to be released to:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Covering the period of health care from (must select one):**

- Specific Date(s): \_\_\_\_\_ to \_\_\_\_\_
- All    Diagnosis: \_\_\_\_\_

**I authorize the following PHI to be released  
from my medical record(s):**

- |  |   |
|--|---|
| <input type="checkbox"/> Pertinent Information                   | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Emergency Room Report                   | <input type="checkbox"/> Lab Results        |
| <input type="checkbox"/> Consultations                           | <input type="checkbox"/> Pathology Results  |
| <input type="checkbox"/> Operative Reports                       | <input type="checkbox"/> Pathology Slides   |
| <input type="checkbox"/> Radiology Reports                       | <input type="checkbox"/> Discharge Summary  |
| <input type="checkbox"/> Radiology Films/Other Diagnostic Images |   |
| <input type="checkbox"/> Complete Billing Record/Itemized Bill   |   |
| <input type="checkbox"/> Complete Health Record                  |   |
| <input type="checkbox"/> Other: _____                            |   |

**Purpose for requesting Information (must select one):**

- |   |  |                                    |                                       |
|---|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Disability                   | <input type="checkbox"/> FMLA            | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal        |
| <input type="checkbox"/> Medical                      | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Personal  | <input type="checkbox"/> Adoption     |
| <input type="checkbox"/> Research                     | <input type="checkbox"/> School          | <input type="checkbox"/> Military  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Department of Social Service |  |                                    |                                       |

**Please check one if patient is deceased.**

**I hereby represent that I am:**

- The agent appointed by the deceased in a Durable Power of Attorney for Health Care or a guardian appointed for the deceased. **(Please attach copy of document designated appointment.)**
- The executor, administrator or court-appointed personal representative for the deceased patient. **(Please attach copy of the order of appointment.)**
- Entitled to bring a wrongful death action under Section 537.080 RS.Mo for the death of the deceased patient and am requesting the above described medical records for purposes of considering possible legal action under the statute. My relationship to the deceased is **(circle one):**

spouse    child    parent.

- The beneficiary of an insurance policy covering the life of the deceased patient. **(Please attach copy of the policy.)**
- A devisee, legatee, or heir at law that is claiming under the deceased patient in a currently pending will contest and am requesting the above described medical records in connection with such proceeding. **(Please attach copy of the petition.)**

**By signing this authorization form, I understand that:**

- Protected health information may include records relating to mental health care, sexually transmitted diseases, Genetic/Metabolic Testing, HIV/AIDS, and/or treatment of alcohol/drug abuse.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Management Department. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: \_\_\_\_\_. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this authorization, and that I can inspect or copy the protected health information to be used or disclosed.
- I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Mosaic Life Care, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Patient or Authorized  
Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of Patient or  
Authorized representative: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Identification type: \_\_\_\_\_ Verified by: \_\_\_\_\_ Date: \_\_\_\_\_

\*If signed by patient's personal representative, supporting legal documentation must accompany this authorization form\*

### Spanish (Español)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-816-271-1215.

### Vietnamese (Tiếng Việt)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-816-271-1215.

### Chinese (繁體中文)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-816-271-1215。

### Serbo-Croatian (Srpsko-hrvatski)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-816-271-1215.

### German (Deutsch)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-816-271-1215.

### Korean (한국어)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
1-816-271-1215 번으로 전화해 주십시오.

### French (Français)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-816-271-1215.

### Arabic (العربية)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية متوفّرة لك بالمجان. اتصل برقم 1-5121-172-618

### Karen (unD)

ပုဂ္ဂနယ်ပြည်သူ့ - နမူးကတီ၊ ကည်းကိုယ်အောင်၊ နမေန်၊ ကိုယ်အတ်မေစာလာ၊ တလော်ဘူးလှိုင်စုံ၊ နိုတ်မြေဘာ်သူနှင့်လို့ ကို  
1-816-271-1215

### Burmese (မြန်မာဘာ)

သတ္တဝါပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကျအညီ၊ အခဲ့၊ သင့်အတွက်  
မိမိအောင်ရွက်ပေါ်ပါမည်။

ဖုန်းနံပါတ် 1-816-271-1215 သို့ ဒေါ်ဆိပ်။

### Russian (Русский)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-816-271-1215.

### Laotian (ພາສາລາວ)

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຈ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ແສງຄ່າ, ດັ່ງນີ້ແມ່ນໄຫ້ທ່ານ.  
ໂທ 1-816-271-1215.

### Tagalog (Tagalog)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-816-271-1215.

### Cushite (Oroomiffa)

XIYYEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidaan ala, ni argama. Bilbilaa 1-816-271-1215.

### Pennsylvania Dutch (Deitsch)

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Rufelli Nummer uff: Call 1-816-271-1215.

### Japanese (日本語)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-816-271-1215まで、お電話にてご連絡ください。

### Trukese (Foosun Chuuk)

MEI AUCHEA: Ika iei foosun fonoowm: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-816-271-1215.