Processed by _____(initial) Provider _____

Community Health Center of Central Missouri
Authorization for Use and Disclosure of Protected Health Information

Patient Name (Last, First, MI): _____ **DOB:** _____

Former Name (if applicable): _____ **Phone:** _____

Address: _____

Please send my records FROM:

☐ **Community Health Center of Central Missouri**

☐ **Other:**

Sender Name (Provider/Clinic/Hospital): _____

Address: _____

Phone: _____ **Fax:** _____

Please send my records TO:

☐ **Community Health Center of Central Missouri** **PO Box 104780 Jefferson City, MO 65101** **Fax: 573-632-2769**

☐ **Other:**

Receiver Name: _____

Address: _____

Phone: _____ **Fax:** _____

Method of Release (mark one): ☐ Fax ☐ Mail ☐ Hold for Pickup ☐ Email: _____

Information to be Released:

☐ Entire Record ☐ Lab/Pathology ☐ Ultrasound Reports ☐ Medication Records ☐ Visit Notes

☐ Immunization Record ☐ Consult Reports ☐ Billing Records ☐ Dental Records ☐ Dental Xrays

☐ Other: _____

Dates Needed: ☐ Last 12 months ☐ Last 24 months ☐ Date Range: ____/____/____ to ____/____/____

Purpose of Disclosure: ☐ Changing Provider ☐ Legal ☐ Consult ☐ Insurance ☐ Other: _____

AKNOWLEDGEMENT OF UNDERSTANDING

I understand by signing this authorization, I am allowing release of any medical information requested by the agency or person specified above. By signing this authorization, I am allowing release of any drug and/or alcohol information, psychiatric, HIV testing and/or results or AIDS information contained within the records to the above named. I understand this authorization will expire when the records requested on this authorization have been released, or in 365 days, whichever occurs first. I understand I may revoke this authorization at any time by notifying Community Health Center of Central Missouri in writing. I understand revocation will be effective on the date my notification is received and dated by Community Health Center of Central Missouri, except to the extent that release of information action has already been taken. I understand information used or disclosed because of this authorization may be subject to additional disclosure by the recipient and may no longer be protected by Federal privacy regulations. I understand by signing or not signing this authorization, my healthcare and payment for my healthcare will not be affected. I understand I may request to see or copy the information described on this authorization and that I may request a copy of this authorization after I sign it.

Signature of Patient/Legal Guardian: _____

Relationship to Patient: _____ **Date:** _____

Witnessed by: _____ **Date:** _____

Jefferson City Clinic
1511 Christy Dr.
Jefferson City, MO 65101

Linn Clinic
316 W Main St
Linn, MO 65051

California Clinic
606 E. Buchanan
California, MO 65018

Fulton Clinic
561 Commons Dr.
Fulton, MO 65251

Administrative Offices
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