PATIENT AUTHORIZATION – RELEASE OF INFORMATION

Patient Name: _____ Birth Date: ____/____/____
(Please Print) MM / DD / YR

Home Address: _____
Street Apt #

_____
City State ZIP Code

Home Telephone Number: ( ) _____ E-mail: _____
Work Telephone Number: ( ) _____

Patient Social Security Number: _____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below whom I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

1. I Authorize the Following Health Information to be Used and/or Disclosed.

_____
_____

2. I Authorize the Following Persons/Organizations to Receive, Use and/or Disclose My Health Information.

_____
_____

3. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

_____
_____
_____

4. My Right to Revoke This Authorization: I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the ***Audrain County Health Department Privacy & Security Officer, 1130 South Elmwood, P.O. Box 957, Mexico, MO, (573)581-1332.***
I am aware that my revocation will not be effective if:

(i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or;
(ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

(iii) as required and/or authorized by law.

5. Redisclosure of My Health Information: I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

6. Disclosure of Direct or Indirect Remuneration Received By Any Person and/or Organization Authorized to Use and/or Disclose My Health Information: I understand that no one will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.

7. Expiration of Authorization: This authorization will be effective for one (1) year from the date of signature.

_____ _____/_____/_____

Patient Signature **Date**

If Patient is unable to sign, personal representative must complete the following:

Patient is unable to sign because: _____

Name of Personal Representative and Relationship to Patient: _____

_____

Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, other statutory authorization): _____

Home Address: _____
Street Apt #

_____
City State ZIP Code

Home Telephone Number: (___)_____ E-mail: _____

Work Telephone Number: (___)_____

_____ _____/_____/_____

Signature of Personal Representative Date