OZARKS COMMUNITY HOSPITAL

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____ Phone: _____

I request my protected health information (PHI) from:

- ☐ OCH-Springfield
- ☐ OCH-Gravette
- ☐ Behavioral Health
- ☐ Christian County Clinic
- ☐ Gravette Clinic
- ☐ Jasper County Clinic
- ☐ Lawrence County Clinic
- ☐ Noel Clinic
- ☐ Northside Clinic
- ☐ North Pediatrics
- ☐ Pain Clinic
- ☐ Polk County Clinic
- ☐ Primary Care Clinic
- ☐ Primrose Clinic
- ☐ Specialty Clinic
- ☐ Webster County Clinic
- ☐ Wellpointe Clinic

☐ Other Hospital or Provider: _____

I authorize and request OZARKS COMMUNITY HOSPITAL to:

_____ **RELEASE** information to: _____ **OBTAIN** information from:

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

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

- ☐ Abstract/Hospital Summary (Dictated reports/Lab/Radiology)
- ☐ Emergency Room Record
- ☐ Laboratory Report (s)
- ☐ Radiology Report (s)
- ☐ Radiology Film/Image (s)
- ☐ Complete Medical Record
- ☐ Clinic Visits
- ☐ Psychotherapy Visits
- ☐ Itemized Billing
- ☐ Other _____

Covering the period of health care from:

☐ From Date (s): _____ to Date (s) _____

Purpose for requesting information:

☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- PHI may include reports relating to mental health care, communicable diseases, 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 90 days from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient/Authorized Representative Signature: _____ Date: _____

Authority to Sign if not patient: _____

OFFICE USE ONLY

Identity of Requestor Verified: ☐ Photo ID ☐ Matching Signature ☐ Other (specify) _____

Verified By: _____