**Form 2 YCMC Authorization for Release of Information**

**Patient's Name**

**Patient's Address**

**City**

**State**

**Zipcode**

# I AUTHORIZE RELEASE OF INFORMATION TO YOUR CONVENIENT MEDICAL CARE REBECCA MCCLAIN FNP 215 NORTH ST. P.O. BOX 4475 WAYNESVILLE MO 65583 /FAX# 573=0774-5626

**Date(s) of Service Requesting**

# I AUTHORIZE TO OBTAIN INFORMATION FROM:

**Name/Hospital/Clinic/Doctor/Other**

**Address**

**City**

**State**

**Zipcode**

**Phone Number**

**Fax Number**

**Dates of Service Requesting**

**Information to be released:**

|  |  |  |
| --- | --- | --- |
| All Medical Records |  Emergency Room |  Operative Report |
| Laboratory Results |  Radiology Report/Images |  History and Physical |
| Discharge Summary |  Abstract |  |

# THE FOLLOWING WILL NOT BE RELEASED UNLESS I INITIAL:

**Psychiatric/Mental**

**Chemical Dependency**

**Reference to AIDS/HIV**

# INFORMATION RELEASED WILL BE USED FOR:

**Continuing Care**

*Please Specify*

**Insurance**

*Please specify*

**Litigation**

 Yes  No

**Other**

*Please explain*

**Authorization** (choose one)

 I understand that I may revoke this authorization at any time by written request.

 I understand that the revocation will not apply to information already released in response to this authorization.

 I further authorize that a photocopy or facsimile of this authorization will be treated in the same manner as the original.

 I understand that this authorization will expire six (6) months from the date of my signature unless otherwise specified.

 I understand that this authorization is not valid for future dates of service(s).

 If you are signing on behalf of a patient for whom you are legally responsible, you must present appropriate certification.

 If you are signing on behalf of a deceased patient, you must complete an Authorization for Release of Deceased Patient's Health Information

**Signature of Patients/Legal Guardian/Personal Representative**

**Date**

**Time**

**Relationship**

**Witness**

# PROHIBITION OF REDISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FOR RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW 42.F.A, PART 2. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY

LAW. THE GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE