

**Ozarks Community Hospital**  
**PO Box 9227 Springfield, MO 65801-9227**

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:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> OCH Hospital      | <input type="checkbox"/> Sparta Clinic              | <input type="checkbox"/> Carthage Clinic  | <input type="checkbox"/> Anderson Clinic       |
| <input type="checkbox"/> Gravette Clinic   | <input type="checkbox"/> Rogersville Clinic         | <input type="checkbox"/> Webb City Clinic | <input type="checkbox"/> Southwest City Clinic |
| <input type="checkbox"/> Decatur Clinic    | <input type="checkbox"/> Mt. Vernon Clinic          | <input type="checkbox"/> Neosho Clinic    | <input type="checkbox"/> Pineville Clinic      |
| <input type="checkbox"/> Avoca Clinic      | <input type="checkbox"/> Evergreen Clinic           | <input type="checkbox"/> Noel Clinic      | <input type="checkbox"/> Goodman Clinic        |
| <input type="checkbox"/> Wellpointe Clinic | <input type="checkbox"/> Other Hospital or Provider |   |  |

**I authorize and request Ozarks Community Hospital to:**

\_\_\_\_\_ **RELEASE** information to: \_\_\_\_\_ **OBTAIN** information from:

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

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

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

Fax or Mail Information To:

**OCH Medical Records**

PO Box 9227

Springfield, MO 65801-9227

Phone: 417-837-2050

Fax: 417-837-2075

**Is this request for PHI relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse, which may include psychotherapy notes and/or records regarding a Substance Abuse Disorder?**

**Yes, then you are authorizing the release of such information, and it will be the only records released by this authorization. You must submit another authorization for other items below.**

**No, then you may check as many items below as you need.**

- |   |  |
|---|--|
| <input type="checkbox"/> Abstract/Hospital Summary (Dictated reports/Lab/Radiology) | <input type="checkbox"/> Complete Medical Record |
| <input type="checkbox"/> Emergency Room Record                                      | <input type="checkbox"/> Clinic Visits           |
| <input type="checkbox"/> Laboratory Report (s)                                      | <input type="checkbox"/> Itemized Billing        |
| <input type="checkbox"/> Radiology Report (s)                                       | <input type="checkbox"/> Other (describe):       |
| <input type="checkbox"/> Radiology Film/Image (s)                                   |  |

**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:**

- I may refuse to sign this authorization and that my authorization is strictly voluntary.
- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- 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: \_\_\_\_\_