AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Golden Valley Memorial Healthcare

For records being released to GVMH, please send to following location. (check the box)

❑ **Hospital**	❑ **Clinton Clinic**	❑ **Osceola Clinic**	❑ **Warsaw Clinic**	❑ **Windsor Clinic**
1600 N Second	1602 N Second	675 Third Street	1771 Commercial	100 South Tebo
Clinton, MO 64735	Clinton, MO 64735	Osceola, MO 64776	Warsaw, MO 65355	Windsor, MO 65360
Tel: (660) 885-5511	Tel: (660) 885-8171	Tel: (417) 646-2231	Tel: (660) 438-5193	Tel: (660) 647-2147
Fax: (660) 885-5012	Fax: (660) 890-8492	Fax: (417) 646-2338	Fax: (660) 438-9427	Fax: (660) 647-2160

Patient's Name : ______________________ DOB: ______________

I authorize Golden Valley Memorial Healthcare to ❑ release to or ❑ obtain from:

Name of Person/Facility/Insurance Company ______________________ Telephone/Fax Number

Complete Mailing Address ______________________

Provider Requesting Records:______________________

Dates of Information to be released: From: ______________ To: ______________

The type of information to be used or disclosed consists of:

❑ Pertinent Documentation	❑ Operative Report	❑ Lab results	❑ Complete Health Record
❑ History and Physical	❑ Consultation Reports	❑ EKG	❑ Progress Notes
❑ Discharge Summary	❑ X-ray Reports	❑ EEG	❑ X-ray Images On-disc
❑ Photographs, Videotapes	❑ Billing Records	❑ Itemized Bill	❑ Psych. Evaluation

❑ Other (please describe) ______________________

I understand that my health records may include information about sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol, drug abuse and mental health.

This authorization contains restrictions ❑ Yes ❑ No If yes, list restrictions:

____

The information is to be used for the purpose of:

❑ Follow-up care/further treatment ❑ Disabilty ❑ Insurance determinations ❑ Work Comp

❑ Legal ❑ Other/Personal

I understand that my treatment or payment for my treatment cannot be conditioned on the signing of this Authorization. I understand that information disclosed pursuant to this Authorization may no longer be protected and could be re-disclosed.

Except to the extent that action has already been taken in reliance on this Authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at (1600 N. 2nd, Clinton, MO 64735). **Unless revoked, this authorization will expire in 90 days from the date signed.**

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility may charge fees in accordance with the HIPAA Privacy Rule or Missouri law as applicable. An estimate of the fee may be obtained by contacting the Privacy Officer at (660) 885-5511 or by writing the Privacy Officer at the address noted above.

______________________ ______________________ ______________

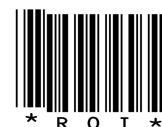
Signature of Patient/Guardian/Legal Representative | Relationship to Patient | Date

______________________ ______________

Witness Signature: | Date

❑ Completed ______________ ______________ ❑ Sent to HIM

Initials | Date



GV-1218 (10-19) HIM