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**	☐**Home Services**	☐**Hospice**
1600 N Second	1602 N Second	675 Third Street	1771 Commercial	100 South Tebo	1617 N Second St.	725 E. Ohio St.
Clinton, MO 64735	Clinton, MO 64735	Osceola, MO 64776	Warsaw, MO 65355	Windsor, MO 65360	Clinton, MO 64735	Clinton ,MO 64735
Tel: (660) 885-5511	Tel: (660) 885-8171	Tel: (417) 646-2231	Tel: (660) 438-5193	Tel: (660) 647-2147	Tel: (660)885-5088	Tel:(660)890-2014
Fax: (660) 885-5012	Fax: (660) 890-8492	Fax: (417) 646-2338	Fax: (660) 438-9427	Fax: (660) 647-2160	Fax: (660)890-7425	Fax(660)890-2018

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 ☐ Disability ☐ 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. Second, 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