



University Hospital

University of Missouri Health System

University Hospital Medical Records
One Hospital Drive, DC042.00
Columbia, MO 65212
Phone (573) 882-3170
Fax (573) 882-3209

please place patient label here

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO UNIVERSITY OF MISSOURI HEALTH SYSTEM

Patient Name: _____ DOB: _____ SSN: _____

Address _____ City, State Zip _____ Phone Number _____

I, _____ hereby authorize UMHS to obtain my medical records from:
Name of Patient

Name of Institute & Contact Person _____ Phone Number _____

Address of Institute Releasing Information _____ Fax Number _____

Please mail or fax records to:

University Hospital
Medical Records ROI
One Hospital Drive,
DC042.00 Columbia, MO
65212

573.884.DOCS 573.884.3627

PERSON TO BE CONTACTED WHEN RECORDS ARE RECEIVED:
Contact Name _____ Contact Phone #: _____
Pending appointment date and time (if applicable): _____

The following information is requested for release:

- Admission Note, Operative Report and/or Diagnostic Tests, Discharge Summary, Progress Notes, Consultations, Physicians Orders, Nurses Notes, Emergency Room Report, Ambulance Record, Radiology Reports, Laboratory Reports, Surgical Pathology, Clinic Notes, Autopsy Report, Radiology Films (CD copy)

Dates of treatment to be released: From: _____ to _____.



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Release of this information is being made for the following purpose: (Describe the reason for the request)

PSYCHIATRIC, DRUG AND/OR ALCOHOL ABUSE, HIV/AIDS RECORDS RELEASE:

I understand if my medical or billing record contains information in reference to psychiatric testing and/or treatment I agree to its release. Check one: Yes No

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. Check one: Yes No

I understand if my medical or billing record contains information in reference to HIV/AIDS testing and/or treatment I agree to its release. Check one: Yes No

You may request to inspect or copy the information that the institute intends to disclose. UMHS may NOT require that you sign this authorization to receive treatment. You may refuse to sign this authorization. If you refuse to sign this authorization, the requested information will not be released. Once release of this information is disclosed to the above named person or persons, your information may be subject to re-disclosure by that person or persons. You may revoke this authorization at any time, except to the extent that the sending institute has already released information in reliance on this authorization. Typically, this is accomplished on our Revocation Form, but alternative means of notice are acceptable. Unless you revoke this authorization, this authorization will expire on the following date or condition. If you do not fill out a specific date or condition upon which this authorization will expire, it will automatically expire six months from the date of your signature.

I, have read the above information and authorize UMHS to request the identified information from the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge the above institution from any liability and will hold that institution harmless for any release made pursuant to this authorization. A copy of this authorization will be available to you after you sign it.

Signature of Patient or Legal Representative

Date

If signed by the Legal Representative, he or she should describe the nature of his or her authority to sign for the patient and attach a copy of the documentation.

If you are obtaining an authorization for disclosure of PHI created for research purposes, please contact the Institutional Review Board (IRB), as such an authorization requires detailed information beyond the scope of this document.