FAMILY CARE CLINICS
Rural Health Clinics of
Bates County Memorial Hospital

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AUTHORIZATION TO ACCESS/DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize: _____ Phone number:_____
to release healthcare information of the patient named above to:

Family Care Clinics
PO Box 370
Butler, MO 64730

For the purpose of continued treatment.

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ◯ Radiology Reports
- ◯ Progress Notes
- ◯ Pathology Reports
- ◯ Other_____
- ◯ EKG's
- ◯ Laboratory
- ◯ Entire Record

Dates of Treatment_____

☐ I understand that the information in my health record may include information relating to STDs, AIDS/HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse (including alcohol and drug screening tests).

☐ I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

☐ I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the hospital's Privacy Officer.

Signature of Patient or Legal
Representatiive:_____Date:_____

Relationship to Patient if Representative:_____

Witness:_____Date:_____